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Volume 79 Number 1
January 1983

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THE FIRST STATE INSTITUTION WEST OF THE ALLEGHENIES

Mental health care in West Virginia began in 1858—before statehood—when the Virginia Assembly autharized construction af the first public institutian west of the Alleghenies, at Weston.[1]

Completed by West Virginia, it opened in 1864 as the Trans-Allegheny Lunatic Asylum, consisting of three one-story buildings housing nine patients. The asylum was virtually the only tangible property West Virginia had to show for its share of the disputed Virginia debt of more than 13 million dollars at the end of the War Between the States.[1]

A self-sufficient institution

By 1880, the main building had grown to nine acres of floor space—a handsome gray stone structure said to be the largest hand-cut stone building in the country. Planned ta be as self-sufficient as possible, the main building was set on a 350-acre farm that supplied the institution's kitchen.[1] To this day, Weston Hospital, as it is now known, maintains its own laundry, plumbing, maintenance and repair shops on spacious grounds.[2]

More important, it has served—and continues to serve—the mental health requirements af the people of West Virginia with the most advanced skills and sciences. In 1957, Weston reached a remarkable capacity of 2300 patients[2]—a far cry from the original nine—a tribute to the growth of this historically significant hospital.

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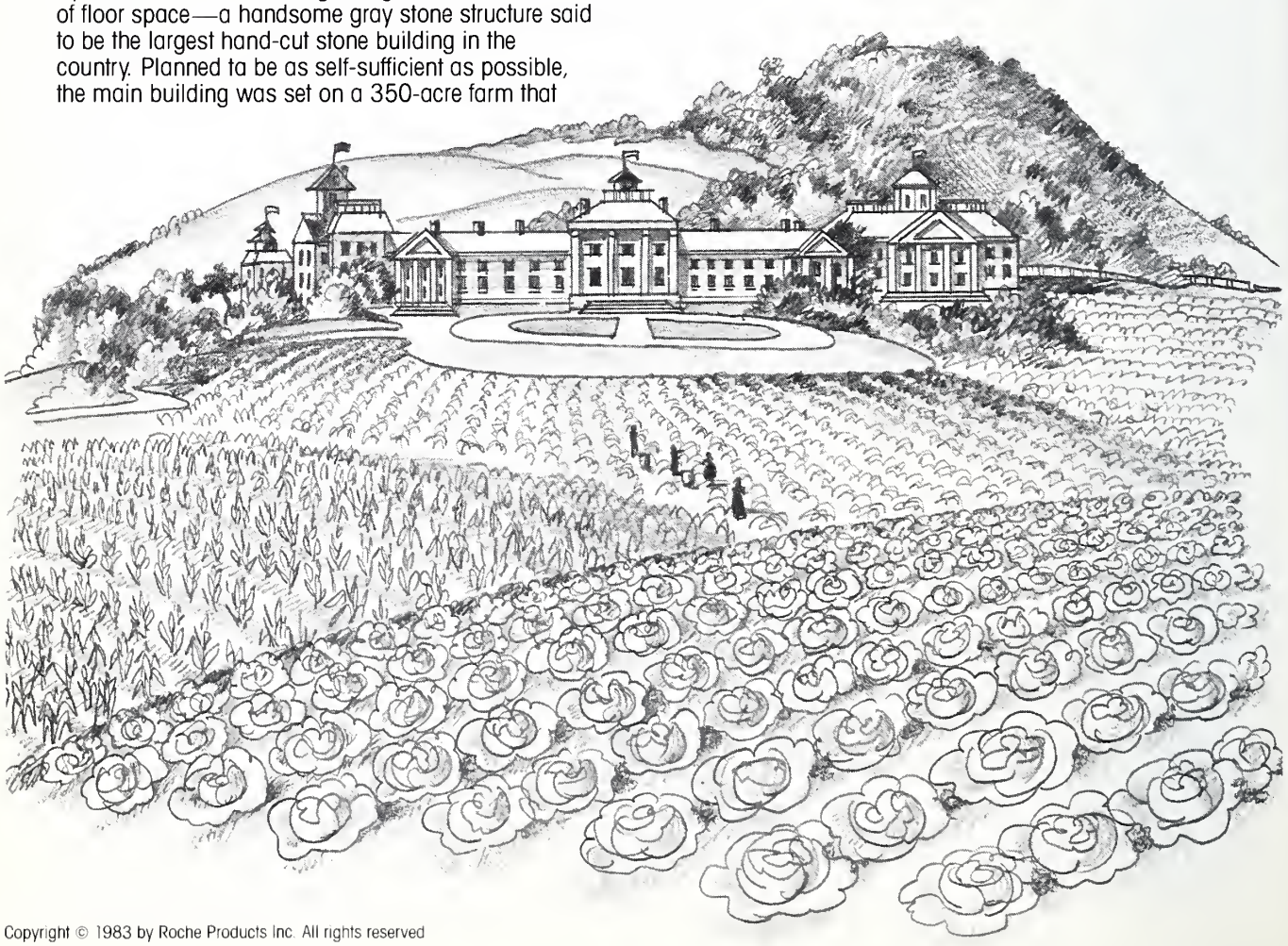

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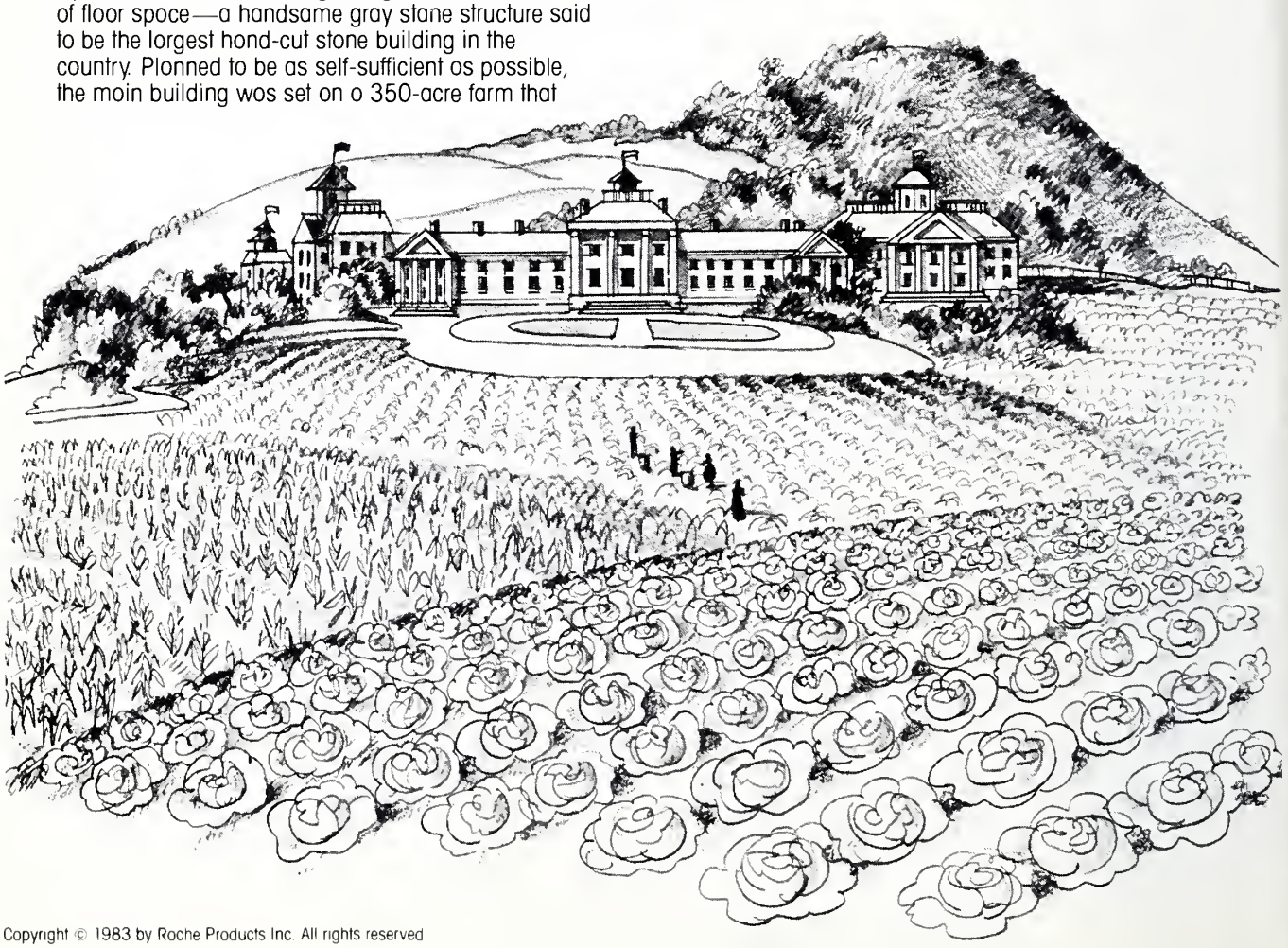

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Roche salutes
the history of West Virginia medicine

THE FIRST STATE INSTITUTION WEST OF THE ALLEGHENIES

Mental health care in West Virginia began in 1858—before statehood—when the Virginia Assembly authorized construction of the first public institution west of the Alleghenies, at Weston.[1]

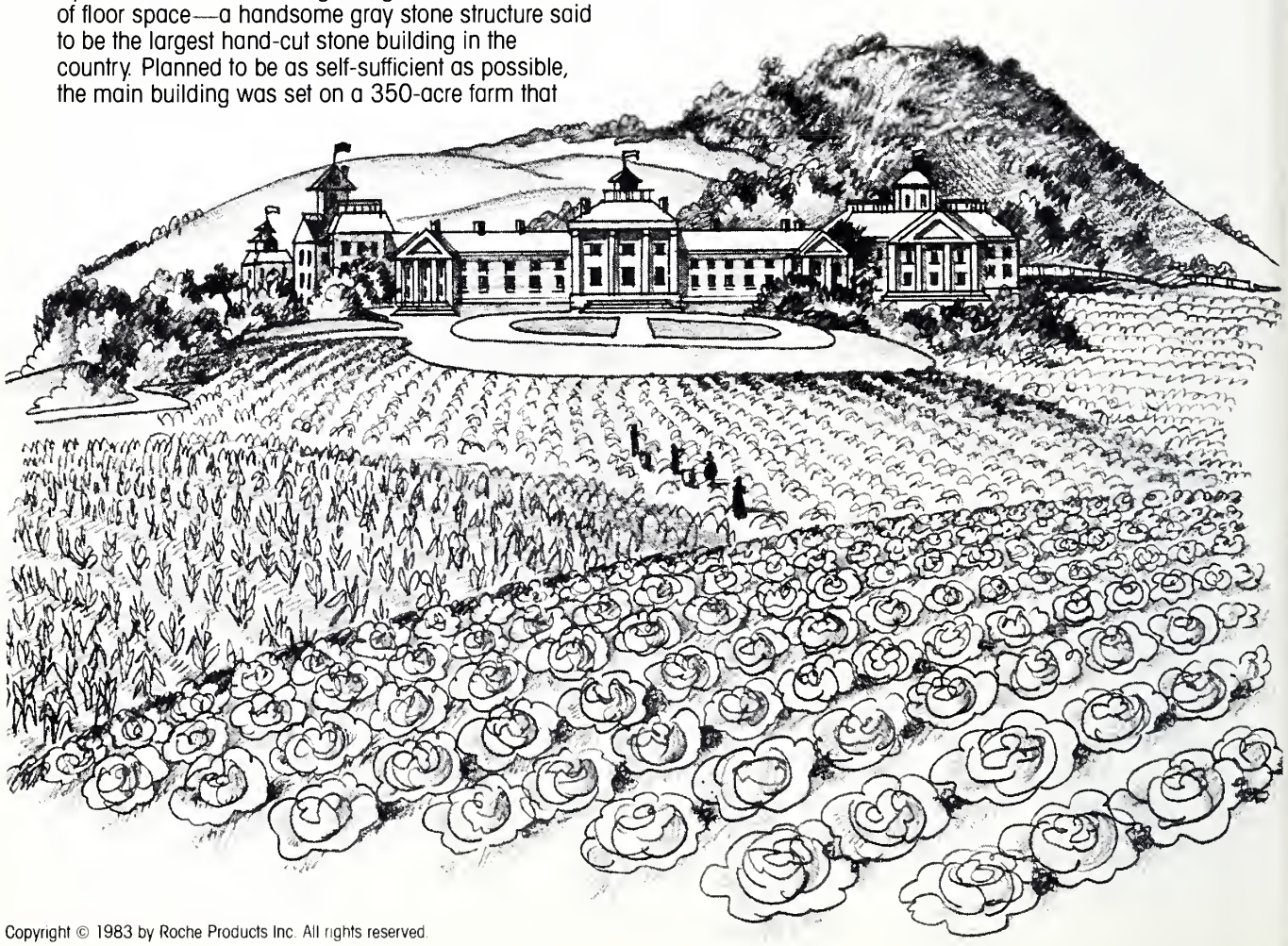
Completed by West Virginia, it opened in 1864 as the Trans-Allegheny Lunatic Asylum, consisting of three one-story buildings housing nine patients. The asylum was virtually the only tangible property West Virginia had to show for its share of the disputed Virginia debt of more than 13 million dollars at the end of the War Between the States.[1]

A self-sufficient institution

By 1880, the main building had grown to nine acres of floor space—a handsome gray stone structure said to be the largest hand-cut stone building in the country. Planned to be as self-sufficient as possible, the main building was set on a 350-acre farm that supplied the institution's kitchen.[1] To this day, Weston Hospital, as it is now known, maintains its own laundry, plumbing, maintenance and repair shops on spacious grounds.[2]

More important, it has served—and continues to serve—the mental health requirements of the people of West Virginia with the most advanced skills and sciences. In 1957, Weston reached a remarkable capacity of 2300 patients[2]—a far cry from the original nine—a tribute to the growth of this historically significant hospital.

References: 1. Writers' Program: *West Virginia: A Guide to the Mountain State*. New York, Oxford University Press, 1956, p. 363. **2.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.



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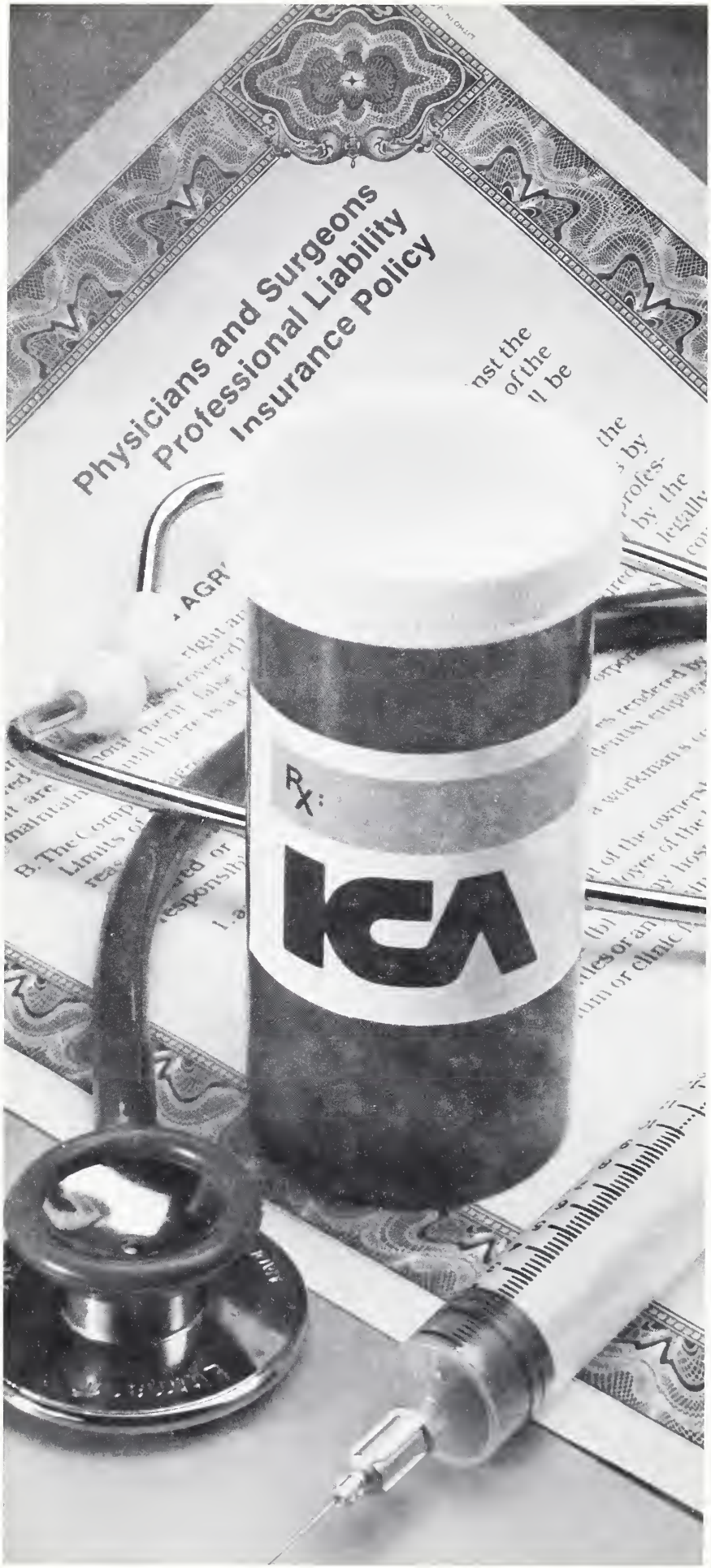

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Vol. 79, No. 1 January, 1983

Postmastectomy Breast Reconstruction*

GEORGE B. IRONS, M. D.
Section of Plastic and Reconstructive Surgery, Mayo Clinic and Mayo Foundation, Rochester, Minnesota

Postmastectomy breast reconstruction is appropriate and worthwhile for any patient with a good prognosis who strongly desires reconstruction. With the several techniques available, reasonably good results generally can be obtained. Examples of those various techniques are presented, discussed and illustrated.

Each year in the United States approximately 100,000 women are diagnosed as having breast cancer. Most of these women will be treated surgically. The resultant deformity is a heavy burden for these women to bear the rest of their lives. In the past, their options have been either to do nothing or to wear an external prosthesis. More recently, a third option, which is more acceptable to many women, is surgical breast reconstruction.

Breast reconstruction, owing to a number of factors, has become more accepted. First, the ablative surgery has become less radical because the disease is diagnosed at an earlier stage than previously; and, with proper case selection, the results with preservation of the pectoral muscles and enough skin for closure are as good as they are with radical removal of these structures. Adjunctive irradiation and chemotherapy have improved the survival of patients with cancers of stages II and higher.

Second, technical progress in breast reconstruction now permits reconstruction in almost any patient with an acceptable result. With the development of silicone prostheses and the design of new flaps, the reconstructive procedure has become less complicated, and the results are more acceptable.

Third, patient awareness and acceptance of breast reconstruction is increasing. As one patient said, "The mastectomy may have saved my life, but the reconstruction made it worth living." The woman who has undergone reconstruction feels more feminine and more secure socially and sexually.

The advantages of breast reconstruction are that the reconstructed breast is incorporated in the body image whereas the external prosthesis is not, clothes are easier to fit, and there is more freedom of movement without fear of dislodgment of an external prosthesis.

Indications

Almost any patient with a favorable prognosis who desires breast reconstruction and who is an acceptable operative risk is a candidate for reconstruction. The main considerations are the pathology of the tumor, the treatment given, and the time interval since treatment. The pathology is important because reconstruction generally should be undertaken only in the patient who has a good prognosis, that is, one who has stage I disease or stage II disease with three or less positive low axillary nodes.

The patient should have had adequate treatment and, if irradiation or chemotherapy is being used as an adjunct to surgery, reconstruction should be delayed until this treatment is completed.

*Presented at the William E. Irons, M. D., Surgical Symposium, Marshall University School of Medicine, Huntington, West Virginia, September 8, 1980.

The timing of reconstruction requires two considerations: the time when the tissues in the mastectomy area will be healed enough for reconstruction, and the length of time one should watch for recurrence before proceeding with reconstruction. While reconstruction can be done any time after mastectomy, most surgeons desire to wait until the wound is well-healed and the scars have matured, about six months after mastectomy. In regard to the length of time one should watch for recurrence before proceeding with reconstruction, obviously, the longer one waits the better. Most recurrences are noted during the first two years. Many patients, however, do not want to wait that long before reconstruction and, since the incidence of local recurrence is low for stage I disease, reconstruction can proceed as soon as the tissues are suitable.

Essentials of Breast Reconstruction

Thorough Analysis of the Patient: The history should include the tumor pathology, extent of spread and treatment given. The mastectomy side should be examined for any residual disease and for suppleness of the skin, scar and pectoral muscle. The other breast should be examined for breast disease, and its size and shape should be noted. A thorough analysis of the patient and her disease helps determine whether she is a candidate for breast reconstruction and the method that is most appropriate.

Careful Planning and Execution: After determining the anatomic situation in a given patient, the surgeon should discuss the options for reconstruction. This discussion always involves reconstructing a breast mound on the mastectomy side. Reconstruction also may involve a nipple-areolar complex, infraclavicular fullness, or anterior axillary fold, depending on what tissues have been removed and what the patient wants replaced. The other breast should be considered at the same time because the most important anatomic goal is symmetry; frequently, the other breast will have to be reshaped to match the reconstructed breast. Also, the possibility of cancer developing in the other breast is a concern to most patients. It should be assumed that whatever factors were responsible for the cancer in one breast are still operating against the second breast.

Other factors are the pathology of the cancer, family history, and the presence of disease in the other breast. Lobular carcinoma has a 30-per cent incidence of bilaterality. If the patient's

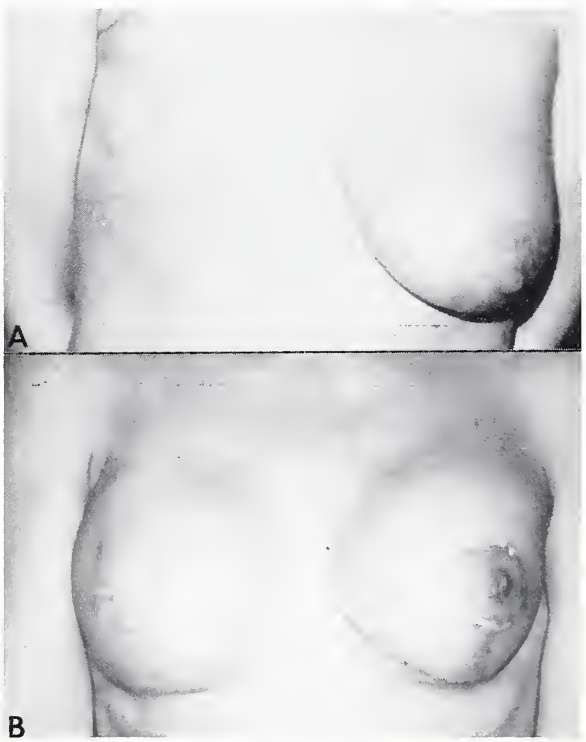

Figure 1. A. After modified radical right mastectomy. B. After reconstruction on right side using available tissue and submuscular silicone implant. Subcutaneous mastectomy and submuscular implant were performed on left side.

Figure 2. A. After modified radical left mastectomy. B. After reconstruction using a thoracoepigastric flap and submuscular silicone implant on the left and subcutaneous mastectomy and submuscular implant on the right.

Figure 3. A. After modified radical mastectomy on the right. B. After reconstruction using latissimus dorsi myocutaneous flap and silicone implant on the right.

Figure 4. A. After right radical mastectomy. B. After reconstruction using omentum and skin graft to cover silicone implant.

mother had breast cancer, the risk is doubled. If the other breast has disease such as duct epithelial hyperplasia, bloody nipple discharge, or extensive fibrocystic disease, the risk of cancer is increased. In these situations, subcutaneous mastectomy of the remaining breast should be considered.

After both sides have been evaluated and the options discussed with the patient, the method of reconstruction can be determined. A successful outcome depends on whether the patient understands what can and cannot be accomplished by the operation. Various methods of reconstruction can be used, but generally, the method should be the simplest and safest one that will give an acceptable result. The breast mound is replaced by a silicone prosthesis. This must be covered by healthy skin and, preferably, by healthy muscle. If the pectoralis muscle is present and the skin is adequate, the simplest method of reconstruction is the creation of a submuscular pocket into which a silicone prosthesis is placed (Figure 1).

If muscle or skin is not available and adequate, then cover for the prosthesis will have to be provided by a flap. The possibilities are the thoraco-epigastric flap,[1,2] which can provide skin (Figure 2); the latissimus dorsi flap,[3-5] which can provide skin and muscle (Figure 3); and the omentum,[6] which can provide cover that will accept a skin graft (Figure 4). The latissimus dorsi flap is the most versatile and dependable and, consequently, is the most frequently used method for supplying soft-tissue replacement.

After the mastectomized side has been reconstructed, attention is then directed to the other side. In some cases, nothing may be required. More often, though, a mastopexy, reduction mastectomy, or subcutaneous mastectomy will be necessary. Again, one should strive for as much symmetry as possible. The main determinants of symmetry are size, shape and position of the inframammary lines.

Construction of a nipple-areola should be deferred until after the wounds are well-healed and the tissues have settled in place; this usually requires 10 to 12 weeks. One can then best determine the proper location for the nipple-areola. Various methods have been employed for this, but the best results have been obtained by a method that utilizes similar tissues for each side. One can make two areolae from one intact areola (Figure 5), or one can transfer medial

thigh skin to the breast as a skin graft (Figure 6). For the nipple, a graft from the intact nipple can be used, or if there is no intact nipple, labia minora tissue can be used for both sides.

Follow-Up and Revisions: For optimal results, the surgeon and the patient must be willing to follow up the surgery with periodic evaluations. For most patients, minor adjustments or revisions of the reconstruction need to be made. In many, these revisions may be done at the same time as the nipple-areolar construction.

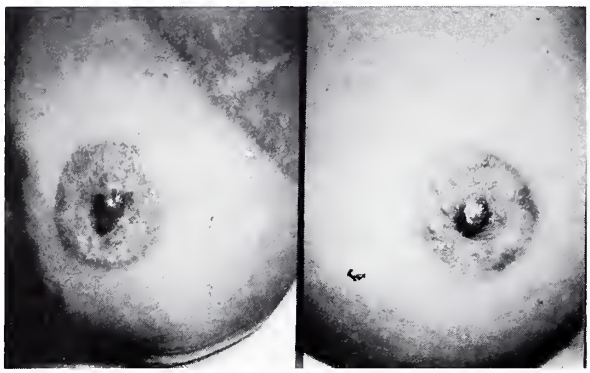

Figure 5. Reconstructed nipple-areola on left using shared tissue from normal right side.

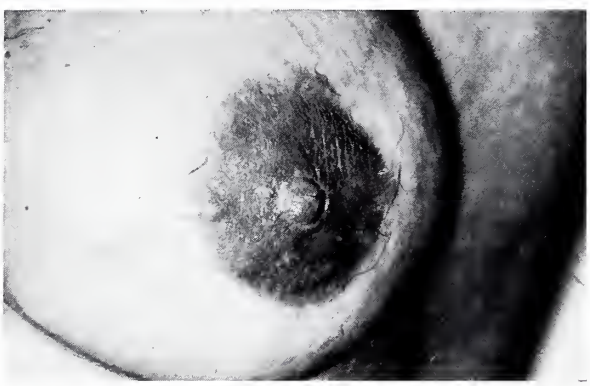

Figure 6. Reconstructed nipple areola using medial thigh skin for areola and free graft from opposite nipple.

Complications

The potential complications of these procedures should be discussed with every patient before operation. Postoperative bleeding and infection may occur after any surgery. Necrosis of skin flaps, implant extrusion, and capsule contracture are possible hazards with breast reconstruction, although they are not common, especially if the prosthesis is placed submuscularly. There is a possibility that reconstruction can cover up local recurrence; however, when the prosthesis is placed behind skin, subcutaneous tissue and muscle, recurrence in these tissues is easily palpable.

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Popliteal Vascular Trauma In Skiers

WALTER B. BLUM, M. D.
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During the winter of 1980 and 1981, two cases of popliteal vascular trauma incurred by skiers were treated at the Memorial General Hospital in Elkins, West Virginia. These two cases are reported with particular attention to the management of these complex injuries.

Most reported traumatic injuries to the popliteal artery in a civilian setting occur from penetrating wounds due to single, low-velocity missiles. A significant number of popliteal arterial injuries also result from blunt trauma, usually caused by motor vehicle accidents.[1] This is a report of two cases of popliteal vascular trauma associated with injuries to the knee incurred while skiing.

Case One

A 21-year-old white female sustained blunt trauma to the right knee while skiing. On admission to the hospital, the right lower extremity was grossly deformed. The right popliteal pulse was absent, as were the right dorsalis pedis and posterior tibial pulses. The patient was taken promptly to the operating room where operative arteriography documented an obstruction of flow at the mid-popliteal artery level. The popliteal space was explored through a posterior "S"-shaped incision, with the patient positioned in the prone position on the operating room table. A large hematoma was evacuated from the popliteal space. The gastrocnemius and plantaris muscles were noted to have been avulsed from their origins. The popliteal artery was noted to be crushed for a one and one-half inch segment near the mid-portion of its passage through the popliteal space.

A primary repair of the injured segment was not technically possible. Accordingly, a short segment of saphenous vein was prepared from the contralateral lower extremity. A two-inch segment of popliteal artery was resected. The reversed saphenous vein was interposed between the two sections of normal popliteal artery. Both anastomoses were performed with #4-0 Ethilon. Distal embolectomy with Fogarty embolectomy catheters was performed and followed by flushing with Heparin/Saline solution. Excellent distal popliteal, dorsalis pedis, and posterior tibial pulses were noted immediately after the arterial circulation had been restored. Multiple fasciotomies were performed in the calf region.

External Skeletal Fixation

When the vascular repair was completed, an external skeletal fixation was employed to maintain reduction of the dislocated knee, with the knee flexed approximately 20 to 30 degrees. This was then reinforced with a padded cylinder cast.

Postoperatively, the patient exhibited swelling of the right lower extremity, particularly in the foot and calf regions; however, the peripheral pulse remained excellent, and the foot remained warm and pink. There was some impairment of dorsiflexion, indicating injury to the peroneal nerve. Non-weight-bearing crutch walking was instituted one week after surgery. Twelve days after surgery, the patient was transferred by plane out of state to convalesce with her family in her hometown.

Case Two

A 16-year-old white male struck his right knee against a stationary object at high speed while skiing. On admission to the hospital, he was noted to have a massively swollen, cold, and cyanotic right lower extremity from the mid-thigh downward. No popliteal, dorsalis pedis, or posterior tibial pulses were detectable by palpation or doppler. Complete instability of the knee joint was noted. The patient had no motor function of the right foot, and was anesthetic from the mid-ankle downward.

The patient was taken quickly to the operating room and placed in the supine position, with the hip abducted and the knee joint maintained in 20 to 30 degrees flexion. The popliteal space was explored through the medial approach. When the popliteal space was opened, a great deal of bleeding was noted. Complete disruption of both the popliteal artery and popliteal vein was discovered.

Vascular control proximally and distally was obtained using Rummel tourniquets. A suitable length of saphenous vein was removed from the contralateral leg; and, after the damaged segments of popliteal artery and vein were resected, a saphenous vein interposition was used to re-establish flow to the right lower extremity.

Reconstructions Flushed

Local Heparin/Saline injection was used to flush both arterial and venous reconstructions. Both were performed using #5-0 Ethilon. Both were end-to-end everting anastomoses. Just prior to the completion of the arterial anastomosis, the embolectomy catheter was passed through the distal arterial tree to remove debris and clots in this region. Once the anastomoses were completed, excellent distal popliteal, dorsalis pedis, and posterior tibial pulses were noted—both by palpation and by doppler.

These excellent pulses remained so throughout the patient's postoperative course. The extremity promptly became warm and pink. The popliteal region exhibited extensive soft tissue damage, with the posterior knee capsule being completely disrupted. Associated tendons and ligaments were markedly deformed and swollen. No obvious identifiable peripheral nerve tissue was observed at this time. The posterior fascial compartment was widely open because of the massive injury.

An anterior compartment fasciotomy was then performed because of severe swelling in this region. At this point, the knee joint was stablized with the application of an external fixation device. This device was tailored for the needs of local wound care and produced satisfactory stability, but this was less than optimal because of the needs of wound care. Because of massive swelling, no cast was applied.

Skin Sutures Removed

Twenty-four hours after surgery, the swelling was noted to be so marked that it necessitated removal of skin sutures from the medial and lateral incisions; however, the vascular structures remained covered by muscle. The lower extremity remained anesthetic from the right ankle on downward. Frequent local wound care was performed using a sterile technique with the application of Betadine-soaked dressings over the medial and lateral incisions.

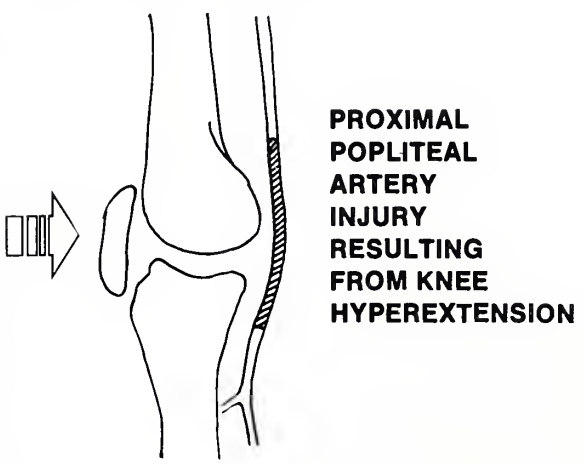

Figure 1.

By the fifth postoperative day, the patient was considered sufficiently stable to be transferred by air ambulance out of state to a medical center close to his residence for the remainder of his care.

Discussion

Mechanism of Injury:

The mechanism of injury for most civilian blunt traumatic vascular injuries to the popliteal region involves physical contact between a moving object and a stationary patient. In the case of the skier, the roles are reversed as he is the moving object who usually strikes a sationary structure, producing sudden hyperextension of the knee (Figure 1) with such force as to produce a range of vascular damage varying from arterial intimal disruption all the way to complete transsection of the popliteal artery and vein. There is a range of associated injuries from partial to complete disruption of the knee joint. with or without fracture dislocation of the femur. tibia, and fibula. Peripheral nerve injury also is frequently associated.

Clinical Findings:

In both cases, the clinical examination disclosed obvious evidence of vascular injury: absent pulses. cool temperature, severe pain, pallor, absence of capillary filling, and significant swelling and deformity at the level of the knee joint. Many authors[1,2,3] stress the urgency of prompt resuscitation and rapid transport from the site of injury to the operating room where restoration of circulation to an ischemic extremity can begin expeditiously.

The first case was in the operating room eight hours after injury, and the second case, five hours after injury. The delay encountered in these two cases was related to the geographic remoteness of the area where the injury occurred and the time necessary to arrange transportation to the hospital. Preoperative arteriography was performed in the first case, and documented the level of arterial obstruction. In the second case, it was felt that the injury was so obvious as to the level of vascular damage that arteriography would simply delay ultimate restoration of flow to a profoundly ischemic leg.

Operative Management:

Two surgical approaches have been described extensively.[1,3] The posterior approach, usually

with the patient in the prone position, was used successfully in the first case. In the second case, the medial approach proved advantageous with the patient in the supine position and the hip abducted. The medical approach is preferred when there are concomitant thoracic and abdominal injuries requiring urgent care. In both cases, segmental resection of the damaged vessel was necessary. In the first case, this was the popliteal artery (Figure 2). In the second case, this was both the popliteal artery and vein (Figure 3).

In both cases, primary end-to-end anastomosis of the damaged vessel was not possible because of the length of traumatized vessel. An appropriate length of autogenous vein graft was removed from the contralateral extremity and used successfully in each case. In the second case, autogenous saphenous vein graft was considered necessary as there was no deep venous conduit remaining; and, with the massive swelling at the time of surgery, it was doubtful that a simple arterial repair in the absence of a venous repair would remain patent. A failure here would result in inevitable limb loss and amputation.[4] In this case, the use of the contralateral saphenous vein was dictated by the need to maintain the ipsilateral saphenous vein as a critically necessary source of venous return.

Systemic heparinization was not used in either case, and was contraindicated in the second case because of massive adjacent musculoskeletal injury. Frequent local Heparin flushes to the distal arterial tree and distal catheter embolectomy were performed prior to the completion of the arterial anastomosis in each case. Distal fasciotomies were required in both cases because of massive swelling and long interval of ischemia to the extremities. Skeletal fixation by external means was used in both instances and was considered essential to the ultimate success of the vascular repair, as well as extremity stabilization.

Results

The major goal was limb salvage, and this was indeed successful in both cases; however, significant morbidity remained, particularly in the second case. Limb swelling resolved slowly in each case. Musculoskeletal problems related to the knee joint instability remained in each case and will require additional corrective surgery. Neurologic deficits also were a problem. In the first case, peroneal palsy was present. In the second case, there was no motor or sensory

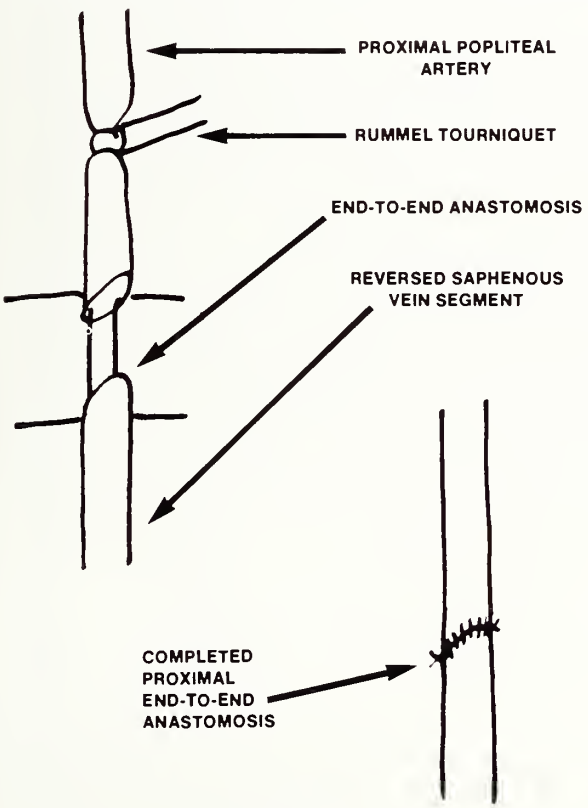

Figure 2.

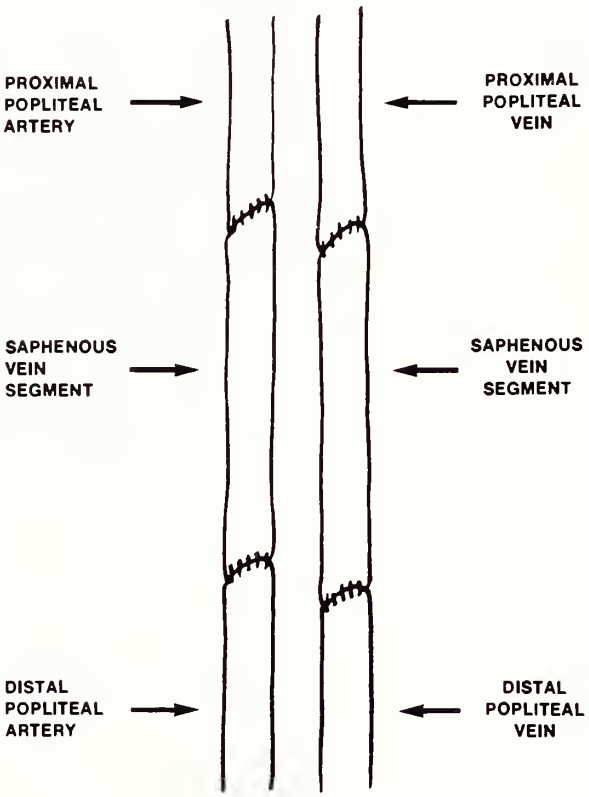

Figure 3.

function from the ankle on downward. This case may require peripheral nerve grafting in the future. At the present time, this patient is ambulatory with the aid of a brace.

One-Year Followup

At one year after surgery, both patients have undergone successful orthopedic reconstructions of the affected knee joint to improve stability and range of motion. Both patients continue to have good peripheral pulses, and are ambulatory, but require bracing of the affected extremity because of the persistence of neurologic deficits.

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1. Snyder III WH, Watkins WL *et al.*: Civilian popliteal artery traumas An eleven-year experience with eighty-three injuries. *Surgery* 1979; 85:101-8.

2. Daugherty EM, Sachatello CR *et al.*: Improved treatment of popliteal artery injuries. *Arch Surg* 1978; 113:1317-21.

3. Abernathy C, Dickinson TC *et al.*: Management of popliteal artery injuries. *Surg Clin* 1979; 59:507-18.

4. Rich NM, Collins GJ *et al.*: The effect of acute popliteal venous interruption. *Ann Surg* 1976; 183:365-8.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (no onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing the most commonly known trade-name drug of that designation. In addition, a listing of all generic drugs mentioned in the article, with their trade-name equivalents, should appear at the end of the article.

A short abstract summarizing the manuscript should be included. This should be typed in double space on a separate page.

Authors are requested to submit a carbon copy with the original.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for reproduction should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. Cost of printing black and white photos in excess of 4 will be billed to author, and no more than 25 references will be published free of charge to the author. A legend should be provided for each illustration and, preferably, attached to it.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

Special Article

Emergency Maternal Transfer: An Ounce of Prevention For West Virginia Newborns

ROSALIND PARKINSON, M.A.
Department of Community Medicine, West Virginia University School of Medicine, Morgantown
ROBERT C. NERHOOD, M. D.
Department of Obstetrics and Gynecology, Marshall University School of Medicine, Huntington, West Virginia

Maternal transfer has occurred at an increasing rate in West Virginia since 1978. As a result, a higher proportion of the state's small prematures are now born in perinatal centers. These infants have experienced lower mortality rates than those born in other hospitals.

THE late 1970s has been a time of accelerated improvement in West Virginia's infant mortality rate (Figure). Much of the increased infant survival is associated with collaborative efforts to regionalize perinatal intensive care on a statewide basis.

Beginning with transfer of sick newborns to three tertiary centers in 1975, the perinatal program progressed in 1978 to organized transfer of mothers before delivery if there were indications of impending problems for unborn infants.* Maternal transfers increased from 104 patients in 1978 to 213 patients in 1980 when they comprised 28 per cent of all perinatal referrals (Table 1).

Vital statistics suggest that maternal referral in West Virginia conforms to the pattern reported for other states where studies indicate that most transfers result from signs of premature labor.[1] While there has been little change in the number of small prematures born in West Virginia, the proportion of these infants born in perinatal centers nearly doubled since maternal transfer has become a viable option (Table 2).

Problems in Procedure

Maternal transfer to improve pregnancy outcome is recommended by organized medicine and government agencies alike.[2,3] However, while it has been demonstrated that there is improved neonatal survival through maternal transfer, problems relating to the procedure spark considerable controversy.[4,5] Women object to transfer from a supportive community environment to an unfamiliar perinatal center. The determination of the need for and the timing of maternal transfer is difficult for physicians. Transfer during early stages of premature labor is often delayed in the hope that labor can be stopped; when premature labor is well advanced, there is a hesitancy to initiate maternal transfer for fear of a precipitous delivery en route to the perinatal center. Sometimes there have been experiences of transfers where neither maternal nor infant transfer was in fact necessary.

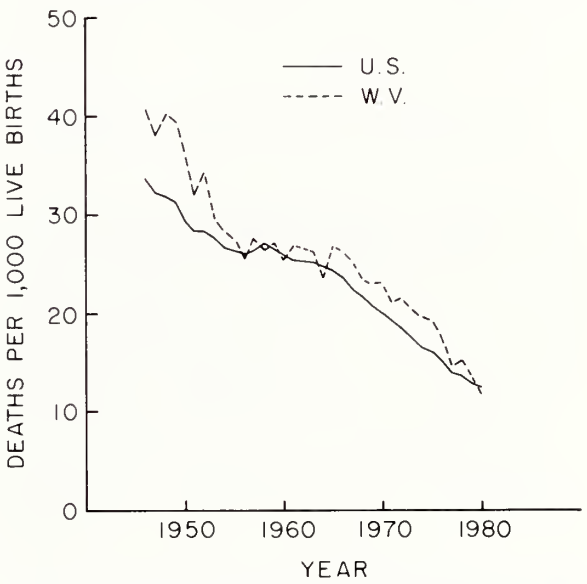

Figure. Infant deaths/1,000 live births, United States and West Virginia, 1946-1980.

Sources:

1) Vital Statistics of the U.S., 1946-1978.
2) Monthly Vital Statistics Report, Annual Summary for 1979, DHHS Pub #(PHS) 81-1120.
3) Health Statistics Center, West Virginia Department of Health, *Vital Statistics* 1965-1979.
4) 1980 Provisional Data NCHS and West Virginia Health Statistics Center.

*The West Virginia perinatal program is sponsored by the West Virginia Department of Health in cooperation with three informally designated perinatal centers including Charleston Area Medical Center, West Virginia University Medical Center and Cabell-Huntington Hospital.

TABLE 1

Perinatal Transfers to Charleston Area Medical Center, West Virginia University Hospital and Cabell-Huntington Hospital, 1974-1980

Year	Total Perinatal #	Total Perinatal %	Before or After Birth: Antenatal #	Antenatal %	Neonatal #	Neonatal %
1974	43	100	NA*	0	43	100
1975	109	100	NA	0	109	100
1976	268	100	NA	0	268	100
1977	428	100	13	3	415	97
1978	556	100	104	19	452	81
1979	651	100	185	28	466	71
1980	763	100	213	28	550	71

*Not available

TABLE 2

Number and Per Cent of West Virginia Resident Infants Weighing Less than 2,000 Grams Born in West Virginia Perinatal Centers, 1974-1979

Year	Infants less than 2,000 grams Born in Perinatal Centers: Number	Per cent of State Total
1974	144	23
1975	143	23
1976	168	29
1977	220	34
1978	245	37
1979	292	45

TABLE 3

Births and Neonatal Deaths Among Less-than-2,000-Gram Infants by Hospitals Where Births Occurred, 1977-1979

Hospitals	Infants less than 2,000 grams: Live Births	Neonatal Deaths	Deaths/1,000 Live Births
Community Hospitals	1192	323	271.0
Perinatal Centers	757	146	192.9
Totals	1949	469	240.6

These drawbacks to maternal transfer are balanced by an awareness that, when born in a community hospital, critically ill neonates requiring immediate and prolonged supportive care must await transfer to a perinatal center. Even though labor and delivery room personnel may have been trained in various technical procedures, e.g., infant resuscitation, infrequent exposure to neonatal stress may result in less than optimal performance in an emergency. In contrast, personnel in perinatal centers manage problems of compromising illness in newborns on a virtually daily basis.

Survival Rate Better

West Virginia's infant mortality statistics show that premature infants are more likely to survive when they are born in perinatal centers. The mortality rate among small prematures born in community hospitals was 40 per cent higher than among those born in perinatal centers in 1977-79 (Table 3). The difference in these weight-specific mortality rates suggests that the medical environment of an infant's birthplace can play an important role in determining life or death. For this reason, it is to be hoped that maternal transfer will continue and perhaps occur even more often in the coming years.

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1. Giles HG, Isaman J, Moore WJ, Christian CD: The Arizona high-risk maternal transport system: An initial view. *Am J Obstet Gynecol* 1977; 128: 400-407.

2. Committee on Perinatal Health: Toward Improving the Outcome of Pregnancy, Recommendations for the Regional Development of Maternal and Perinatal Health Services, the National Foundation March of Dimes, New York, 1977.

3. Guidelines for the Improved Pregnancy Outcome Program permitted federal support for emergency maternal transfer only. No other patient care expenses were allowable under the program.

4. Harris TR, Isaman J, Giles HR: Improved neonatal survival through maternal transport. *Obstet Gynecol* 1978; 52 (3):294-300.

5. Auld PAM: Maternal transport is not the answer. *Perinatology-Neonatology* 1978; 2(2):8.

A Continuing Medical Education Event!

The 16th Mid-Winter Clinical Conference

Charleston Marriott Hotel

309 Lee Street, East, Charleston, WV

January 21-23

West Virginia State Medical Association

West Virginia University School of Medicine

Marshall University School of Medicine

WATCH THE JOURNAL FOR PROGRAM DETAILS

THE PROGRAM CHAIRMAN is Joseph T. Skaggs, M. D., of Charleston. Other members of the Program Committee are William O. McMillan, Jr., M. D., and C. Carl Tully, M. D., both of Charleston; Maurice A. Mufson, M. D., Huntington; Robert L. Smith, M. D., Morgantown, and Richard G. Starr, M. D., Beckley.

THE REGISTRATION FEE of $50 for the entire conference will be charged all registrants except nurses, medical students, interns and residents. Advance registration is requested, and please make checks payable to "WEST VIRGINIA STATE MEDICAL ASSOCIATION."

ACCREDITATION: Attendance will be acceptable for 14 hours of Category 1 credit toward the Physician's Recognition Award of the American Medical Association; and the program also is acceptable for 13 Prescribed hours by the American Academy of Family Physicians.

OVERNIGHT ACCOMMODATIONS: Physicians should communicate directly with the reservation manager of the hotel or motor inn of their choice. The Charleston Marriott was holding a block of rooms for conference attendees through January 3, but reservations after that date may be requested on a space-available basis. In order to obtain group rates, those who make reservations directly with the headquarters hotel should specify that they will be attending the Mid-Winter Clinical Conference. Group rates are $48 for a single room and $54 for a double. Those who register in advance for the Conference with the State Medical Association (see below) will receive from the Association a postage-paid Marriott reservation request card specifically designated for Mid-Winter Clinical Conference registrants.

FOR ADVANCE REGISTRATION, please complete the form below and mail to: WEST VIRGINIA STATE MEDICAL ASSOCIATION, P. O. BOX 1031, CHARLESTON, W. VA. 25324.

- -

Please register me for the 16th Mid-Winter Clinical Conference in Charleston, WV, January 21-23. My $50 registration fee is (is not) enclosed.

Name (please print)	*Specialty*
Address	*City*

A message from . . .

The President

HIGH COST OF DEFENSIVE MEDICINE

THIS month, I would like again to address the broad issue of cost of health care. This topic has been very prominent in the news recently. It is obviously one of the prime concerns of the national administration and our state government, as well as private citizens and the medical profession.

We understand from statistics compiled by the U. S. Department of Health and Human Services that total health care expenditures, public and private, rose 15.1 per cent from 1980 to 1981. We also note, although this is *not* emphasized, that health care expenditures have been rising steadily since Congress created Medicare and Medicaid in 1965 and, a figure noted but *not* emphasized, the average increase from 1976 to 1981 was 13.9 per cent. I am at a loss to see how politicians this year panic over the differential increase of 1.2 per cent from the average 1976 to 1981 figures, especially as HHS states price inflation was responsible for 70 per cent of the increase, and aging of the population for 20 per cent of the increase. Perhaps the reason is that approximately 42.8 per cent of total health care cost was spent by Federal, state and local governments, according to their figures. Perhaps their concerns stem from the realization that the promises they made regarding health care in the past decade are coming home to haunt them, and the bill is far higher than they had anticipated.

Be that as it may, I would like to address another aspect of the cost of medicine which has not been looked at by the politicians, bureaucrats and regulators in their attempt to control the rising cost of health care. This is the field of defensive medicine—the tests that are done not for good clinical reasons but in order to protect the practitioner from legal action and to insure that if legal action is commenced he will be found to have done as much or more than one could or should do.

The rationale for ordering these defensive tests and procedures may be indefensible clinically, but it certainly *is* defensible from a practical, legalistic point of view. One has only to look at the ever-increasing amounts of money awarded to plaintiffs (and incidentally, plaintiffs' lawyers) for relatively minor problems. Examples, such as $800,000 for a misplaced navel or $150,000 because of a scar at an IV site, abound; therefore, the reason for ordering ETKTM (Every Test Known To Man) to CYA (Cover Your A--) is apparent.

I read with interest in the media that physicians' fees rose approximately 9.8 per cent this year while inflation is predicted to be 5-6 per cent and, therefore, our fees are considered to be excessive. Nowhere, however, do I read certain other figures. For example, medical malpractice insurance will average increases in the range of 25 per cent in our state for next year, and utility fees, prices of supplies, and of our phone service show no signs of decreasing, regardless of the decrease in the CPI.

This leads me to believe that a good place to halt the rate of increase in medical care would be to have some attention from the politicians, bureaucrats, regulators and media to provide tort reform to help decrease at least one parameter of the ever-increasing spiral of costs. After all, physicians' costs, like any other professionals', are passed along to our patients, for we have no other sources of revenue. Ultimately, if government at all levels pays 42.8 per cent of the bill, the cost of these exhorbitant awards is borne by every taxpayer, and this is the fact that needs to be brought to his or her attention.

Harry Shannon MD

Harry Shannon, M. D., *President*
West Virginia State Medical Association

The West Virginia Medical Journal

Editorials

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author shall be held entirely responsible. Editorials printed in The Journal do not necessarily reflect the official position of the West Virginia State Medical Association.

GENERAL QUARTERS

In the news section of *The Journal* is a story outlining proposed State Medical Association positions, and efforts to seek passage of several measures, in the upcoming legislative session to begin January 12.

The Association again will be in a posture established and maintained effectively over the past several years—one of offering ideas of its own with respect to promoting the general health and welfare. It proposes to be aggressive in espousing those views—and that's where the general membership must play a role.

Bills related to health and medical care have mushroomed in lawmaking bodies across the nation in the last decade or so, beginning with far-reaching measures introduced into, and frequently enacted by, the Congress.

Some of that legislation is not consistent with such things as cost effectiveness in the true sense of the word—a proper blending of reasonable efforts to blunt costs but at the same time protecting the availability of, and access to, quality care.

That general problem certainly will be a major one with which physicians and others must deal, and play an active role in, during the upcoming session. As always at this time of year, doctors are urged to stay abreast of legislative developments, and in contact with their legislators. The doctors in practice are the constituency of those senators and delegates, not the State Medical Association headquarters.

Every effort will be made, through legislative bulletins and other means, to keep the Association membership informed on as current a basis as possible. But we plead with you to heed those communications, and immediately speak out if you see any problems or have questions.

In other words, we're again going to "general quarters," heading into mid-January. This alert needs to be constantly in your minds—and you need to be ready as your help might be needed.

SURVEYS

Anywhere a physician might care to look these days, he or she can find a new study or survey related to medical or health care. Some of the results might appear positive, others just the opposite—all of which underlines the crazy times in which we live.

Many of the surveys have been by American Medical Association components, and one recently determined that the public had strong pro-physician attitudes on professional liability issues. Most people didn't think malpractice suits usually were justified, although 47 per cent held the opposite view.

The majority (61 per cent) of the respondents in 1,504 telephone interviews favored limits on malpractice awards (something that generally has not been looked upon with favor by the courts across the land). Forty-seven per cent of the public respondents thought current awards have run too high, with seven per cent saying not high enough.

Ninety-two per cent of the 1,000 physician respondents in the AMA survey rated better physician-patient rapport as a very effective method for reducing professional liability risk. No other proposals for reducing risks—such as more peer review, continuing medical education and risk management seminars—got more than a 38-per cent approval rate.

On average, physicians surveyed estimated that 22 per cent of malpractice claims result from actual negligence. Most physicians (62 per cent) said hospital staffs should require evidence of professional liability insurance for staff privileges.

Then there was another recent AMA survey of physicians showing a growing concern over

competition in medicine. An increasing number of physicians believed there are too many doctors in their communities: 33 per cent in 1981 and 40 per cent in 1982.

Fewer than half the physicians surveyed (47 per cent) have been experiencing an increasing patient load in the last few years, and only about one-third (35 per cent) reported their incomes increasing.

Thirty-nine per cent said unemployment lessened their patient load; 67 per cent reported that unemployment had lessened the ability of patients to pay. A current or impending surplus of doctors was foreseen by 72 per cent of those surveyed.

The AMA surveying group concluded that, taken in combination, the study's findings indicated competition for patients was increasing among physicians, and was having a definite impact on medical practice in the nation.

What about concerns regarding medical costs? In still another AMA study, results showed that such concern was growing among physicians and the general public alike. Physician concern over costs increased sharply over a one-year period, while concern about government regulation or access to medical care dropped correspondingly. (We'd suggest that, in the wake of recent congressional action and a flood of new Department of Health and Human Services regulations, feelings about regulation will do another turnabout in the next survey.)

Telephone interviews with randomly selected physicians showed 58 per cent listing cost to be the main problem facing medicine today. Last year, the figure was 44 per cent. In 1,504 telephone interviews with public respondents also selected at random, 62 per cent—as compared to 55 per cent last year—said cost was the main problem facing health care and medicine.

The survey found that almost half (47 per cent) of the American people believed that not enough of society's resources is being directed to health care, and only 16 per cent felt too much is being spent.

But is health care the public's highest priority when it comes to spending more money? No. Public respondents gave a higher ranking to education, the environment and financial assistance to the poor.

All of these survey results will mean somewhat different things to different people. But one of the findings again sticks out like a mountain, and for the third time in this month's editorials we must emphasize it. It's doctor-patient rapport.

MEDICAL PEARLS

The House Staff Council at the Charleston Area Medical Center organized something new this year, at least for that institution. It was a multidisciplinary conference on "Medical Pearls," with some 15 medical specialists presenting short, clinically useful bits of information.

The subjects ranged from nephrology to various aspects of surgery; from pulmonary medicine to obstetrics; and from platelets to vertigo. Perhaps other medical staffs in the state conduct similar conferences, although the CAMC presentations were set up largely for senior medical students and residents. If not, they might want to consider at least the general idea.

Along with observations and subjects directly related to day-to-day practice were reviews of new technology and thinking. And there likewise were some expressions of what commonly can be called good old-fashioned "horse sense."

One internist told the audience to always keep foremost in mind affability, along with ability and availability, in professional relationships with patients.

Humor is very important in the practice of medicine, and if you cannot convey an image of humor, a smile is the next best thing, he said. As for one who finds friendliness beyond his capabilities, it must be back to the proverbial drawing board.

Listen to your patients, said another physician, because they usually will tell you what you need to know—even though you might have to listen "between the lines" to hear it.

He emphasized that "the family can either be your worst enemy or your greatest friend," both in encouraging patient compliance and (along with nurses, secretaries and others) in observing the patient outside the confines of the examining room or office.

Old hat, you say, with respect to these kinds of "pearls?" Rapport is never old hat. It remains the cornerstone of the doctor-patient relationship, a fact never more apparent than in today's complex life patterns.

GENERAL NEWS

Sports Medicine Specialist, Attorney To Speak

A University of Virginia physician who has received numerous awards in the field of sports medicine will be a member of the faculty for the 16th Mid-Winter Clinical Conference, the Program Committee announced.

The annual continuing education program will begin at 2 P. M. on Friday, January 21, at the Marriott Hotel in Charleston, and end at noon on Sunday. The faculty will consist of 13 principal speakers for sessions Friday afternoon and evening, Saturday morning and afternoon, and Sunday morning.

Gary A. Banas, L.L.B.

Sponsors are the State Medical Association and the Marshall University and West Virginia University School of Medicine.

"We believe we have an outstanding faculty, and we have tried to provide many of the subjects requested by doctors," said Joseph T. Skaggs, M. D., Charleston, Chairman of the Program Committee.

Dr. Frank C. McCue III, a native of Maxwelton, Greenbrier County, and a member of the medical staff at the University of Virginia in Charlottesville, will speak on "Sports Medicine for the Family Physician" during the Saturday morning session. He is Director, Hand Surgery and Sports Medicine Division, Department of Orthopedics and Rehabilitation, at the University, and also is Team Physician for the Athletic Department.

Among a number of sports medicine awards received by Doctor McCue are the National Distinguished Service Award from the National High School Coaches Association in appreciation for interest in the care of high school athletes (1977); Certificate of Appreciation from the Medical Society of Virginia for recognition of contributions to Sports Medicine in Virginia (1979); and the National Athletic Trainers Association President's Challenge Award for 1980.

Also Public Session Speaker

Doctor McCue also will be the speaker for the public session Friday evening. "Medical Care for the Athlete—What You Should Know" will be the title of his talk.

As announced previously, a physicians' session on "The Doctor, Quality Control and Professional Liability" will be held concurrently with the public session Friday evening. Gary A. Banas, an Akron, Ohio, attorney, will be the principal speaker. Doctor Skaggs, who is Director of Medical Affairs at Charleston Area Medical Center (CAMC), will preside.

Panelists will be Tom Auman, Director of Professional Liability, McDonough Caperton Shepherd Group, Charleston: Fred Bockstahler, J.D., Director of Patient Affairs, CAMC; James C. Crews, CAMC President; Jack Leckie, M. D., Huntington, Chairman of the Committee on Insurance, West Virginia State Medical Association, and John F. Wood, J.D., Huntington attorney.

Lt. Colonel Fred Donohoe, Chief of the West Virginia State Police, the Program Committee also announced, will make brief remarks during the Saturday morning session. Colonel Donohoe will talk about efforts to secure state funds in 1983 to expand and continue the pilot State Police MEDEVAC air medical rescue program which otherwise expires this month. (See story elsewhere in this issue of *The Journal.*)

'Meet the Faculty'

Other features of the conference will be 5 o'clock "Meet the Faculty" cash bars following the afternoon session on Friday and Saturday, 11 scientific exhibits, and meetings of other medical groups as listed in the program.

Doctor McCue is a Diplomate of the American Board of Orthopedic Surgery, and a Fellow of the American Society of Surgery of the Hand, American Academy of Orthopedic Surgery, American College of Surgeons, and American Society of Sports Medicine. He was a founding

member of the American Orthopedic Society for Sports Medicine.

Doctor McCue received his undergraduate and M. D. (1956) degrees from the University of Virginia. He interned at the Kansas University Medical Center, took a residency in orthopedic surgery at the University of Virginia, and studied surgery of the hand for two years under physicians in Los Angeles.

He is the author or co-author of some 70 scientific articles, and chapters in six books.

Other Speakers

The other previously-announced speakers and topics are:

Friday Afternoon: "Diagnostic Tests in Hepatitis"—Robert H. Waldman, M. D., WVU Professor of Medicine and Acting Dean, School of Medicine, Morgantown; "Vaccines in the Treatment of Hepatitis"—Larry I. Lutwick, Associate Professor of Medicine, State University of New York, Downstate Medical School; and Associate Director, Department of Medicine, and Director, Division of Infectious Diseases, Maimonides Medical Center, Brooklyn; and "Herpes"—Jack M. Bernstein, M. D., MU Assistant Professor of Medicine;

Saturday Morning: "Trauma Transport" — James W. Kessel, M. D., Charleston surgeon; and "Joint Replacement"—J. David Blaha, M. D., WVU Assistant Professor, Department of Orthopedic Surgery; and Chief, Section of Arthritis Surgery, Morgantown;

Saturday Afternoon: "New Developments in Prenatal Diagnosis"— R. Stephen S. Amato, M. D., Ph.D., WVU Professor of Pediatrics and Medical Director, Affiliated Facility for Developmentally Disabled, Morgantown; "Heritable Immunodeficiency Disease — New Prospectives"—Martin R. Klemperer, M. D., MU Professor and Chairman, Department of Pediatrics; and "Nephrotic Syndrome in Children"—Roberta Gray, M. D., MU Associate Professor of Pediatrics:

Lens Replacement

Sunday Morning: "Lens Replacement" — George W. Weinstein, M. D., WVU Professor and Chairman, Department of Ophthalmology, Morgantown; "Use and Abuse of Tricyclic Antidepressants"— William H. Nelson, M. D., Associate Professor of Psychiatry, University of Connecticut, Farmington; and Chief, Ambulatory and Consultation Psychiatry, Veterans Administration Medical Center, Newington, Connecticut; and "Calcium Channel Blockers"—Robert C. Touchon, M. D., MU Associate Professor of Medicine and Chief of Cardiology, Department of Medicine.

Presiding physicians in addition to Doctor Skaggs will be Maurice A. Mufson, MU Professor and Chairman, Department of Medicine (Friday Afternoon); Tony C. Majestro, Charleston, WVU Clinical Associate Professor, Department of Orthopedic Surgery (Friday Evening Public Session); Thomas F. Scott, Huntington, MU Clinical Associate Professor of Surgery (Saturday Morning); Herbert H. Pomerance, Chairman, Department of Pediatrics, CAMC, and Professor and Director of Pediatrics, WVU Charleston Division (Saturday Afternoon); and John W. Traubert, WVU Professor and Chairman, Department of Family Practice, Morgantown (Sunday Morning).

Other Meetings

Other meetings scheduled at the Marriott in conjunction with the conference include the Family Medicine Foundation of West Virginia, Thursday evening, January 20; Board of Directors, West Virginia Chapter, American Academy of Family Physicians, Friday evening; West Virginia State Society of Anesthesiologists, Saturday noon; WESPAC dinner, Saturday evening, and the State Medical Association's Cancer Committee, Sunday morning.

Speakers for the WESPAC dinner will be Peter B. Lauer, Executive Director and Treasurer of AMPAC (American Medical Political Action

Conference Exhibits

Physicians and others attending the 16th Mid-Winter Clinical Conference will have the opportunity to see some 11 scientific exhibits. Exhibitors scheduled to date include:

West Virginia Department of Health; American Heart Association, West Virginia Affiliate; Family Medicine Foundation of West Virginia; McDonough Caperton Shepherd Association Group; Nationwide Insurance—Medicare; American Cancer Society, West Virginia Division, Inc., Kanawha County Unit; Kanawha County Chapter, Physicians for Social Responsibility; Allergy Rehabilitation Foundation, Inc.; West Virginia Lung Association, Inc.; J. B. Lippincott, Division of Harper and Row, Pittsburgh; and Medical Publisher's Representative, Inc., Cincinnati.

Committee) and W. Leonard Weyl, M. D., of Arlington, Virginia, AMPAC Board member.

The program meets the criteria for 14 hours of credit in Category 1 of the Physician's Recognition Award of the American Medical Association, and is approved for 13 Prescribed hours by the American Academy of Family Physicians.

A registration fee of $50 will be charged all registrants except nurses, medical students, interns and residents. For advance registration, make checks payable to West Virginia State Medical Association, and mail to the Association at P. O. Box 1031, Charleston 25324.

Hotel Reservations

The Charleston Marriott was holding a block of rooms for conference attendees through January 3, but reservations after that date may be requested on a space-available basis. Those making reservations—in order to receive group rates—should specify that they will be attending the Mid-Winter Clinical Conference. Group rates are $48 for a single room and $54 for a double.

Other members of the Program Committee are Drs. William O. McMillan, Jr., and C. Carl Tully, both of Charleston; Richard G. Starr, Beckley; Maurice A. Mufson, Huntington, and Robert L. Smith, Morgantown.

The Program Committee is receiving continuing assistance from WVU Charleston Division staff members J. Zeb Wright, Ph.D., Coordinator of Continuing Education, Department of Community Medicine; and Sharon A. Hall, Conference Coordinator.

Joint Appointment For MU, Hospital Announced

The first joint faculty appointment for the Marshall University School of Medicine and Huntington State Hospital has been announced by the two institutions.

Dr. Eric H. Sawitz, Assistant Professor of Family and Community Health, will spend 40 per cent of his time at the State Hospital, where he will be responsible for three wards of developmentally disabled persons. He will work with hospital staff to develop and expand services for the patients.

"We all are interested in developing a relationship between Huntington State and Marshall which would improve patient care," Doctor Sawitz said.

Doctor Sawitz previously served as Medical Director and internist at the Cabin Creek Medical Center in Dawes, and received his M. D. in 1976 from Boston University. He has served as a consultant in internal medicine for the West Virginia Division of Vocational Rehabilitation, and medical consultant and a member of the board of the Kanawha County Special Olympics.

Huntington Burn Unit Taking Referrals

A burn intensive care unit at Cabell-Huntington Hospital in Huntington is now in operation. Designated for the specialized treatment of patients from West Virginia, eastern Kentucky and southwestern Ohio, the burn unit opened formally in November.

The four-bed unit is housed adjacent to the general intensive care unit in the critical care wing. The physicial therapy (hydrotherapy) room is in the unit, and isolation techniques keep it apart from normal traffic patterns.

The planning and design of the unit began in 1977 when the administrators of the hospital took a hard look at its critical care units and decided that, in addition to new facility construction, it would provide a new service as well, that of specialty care of the burn victim.

A group of surgeons, Marshall University surgical residents, burn nurses, physical therapists, dietitians, and social workers apply the "burn team" concept to the patient and his family. The unusually severe disruption of the family by this type of injury is appreciated by the team, and was a compelling reason for the hospital to provide an in-state service for West Virginia and tri-state residents, according to Dr. James A. Coil, Jr., M. D., Professor of Surgery at Marshall University School of Medicine, who is Medical Director of the burn unit.

Referrals

Referring physicians can call the unit directly at (304) 696-6107 for information or patient transfer. In addition, a burn clinic meets for the evaluation of long-term reconstruction and rehabilitation of burn victims.

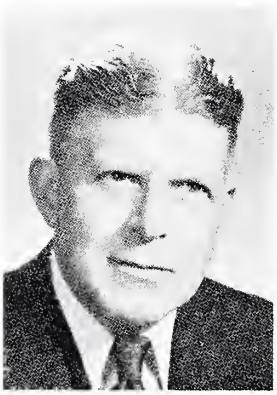
As a guideline for emergency referral, the American Burn Association's criteria for burn unit admission apply: 1. partial-thickness injury

of more than 20 per cent body surface area; 2. full thickness of more than 10 per cent of body surface area; 3. full-thickness burns of the face, hands, or feet; 4. inhalation injury; 5. serious associated medical problems; and 6. electrical burns.

The unit has the hope of being a resource facility for the state, and members of the hospital team are accepting invitations on a limited basis to speak on burn care. An awareness that the best burn treatment is *prevention* will be a major thrust of future educational effort, said Doctor Coil.

Doctor Reed, Past President, Dies In Charleston

Thomas G. Reed of Charleston, President of the State Medical Association in 1949, died on December 7 at his home. He was 84.



Thomas G. Reed, M. D.

A retired urologist and a native of Hardy County, Doctor Reed began practice in Charleston in 1930.

Doctor Reed was a member of the Association's Council from 1945 through 1948, and was an Alternate Delegate to the American Medical Association in the sixties.

He was a member of the former West Virginia Medical Licensing Board from 1965 to 1970.

Doctor Reed was certified by the American Board of Urology, a Fellow of the American College of Surgeons, and a member of the American Urological Association. He received his M. D. degree in 1926 from Jefferson Medical College in Philadelphia.

Doctor Reed was an honorary member, and a Past President of, the Kanawha Medical Society, and an honorary member of the West Virginia State Medical Association and the American Medical Association.

Surviving are the widow; two daughters, Mrs. Frederick H. Belden, Jr., of Charleston and Mrs. Gary C. Caylor of Houston, Texas; three sisters, Mrs. Beulah Heltzel of Wardensville, Mrs. Essye Bean of Moorefield and Mrs. Olga Walker of Wheaton, Maryland, and six grandchildren.

Continuing Education Activities

Here are the continuing medical education activities listed primarily by the West Virginia University School of Medicine for part of 1983, as compiled by Dr. Robert L. Smith, Assistant Dean for Continuing Education, and J. Zeb Wright, Ph. D., Coordinator, Continuing Education, Department of Community Medicine, Charleston Division. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of The Journal.)

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the Morgantown, Charleston and Wheeling campuses. Further information about these may be obtained from: Division of Continuing Education, WVU Medical Center, 3110 MacCorkle Avenue, S. E., Charleston 25304; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 2000 Eoff Street, Wheeling 26003.

Jan. 24-28, Snowshoe, Fourth Mid-Winter Cardiovascular Symposium

Feb. 6-9, Snowshoe, Surgical Conference

March 18, Charleston, 10th Annual Newborn Day

March 25-26, Morgantown, Infection Control Workshop

March 28-29, White Sulphur Springs, Symposium on Tumors for the Orthopedic Surgeon

Regularly Scheduled Continuing Education Outreach Programs from WVU Medical Center/ Charleston Division

Cabin Creek, Cabin Creek Medical Center, Dawes, 2nd Wednesday, 8-10 A. M.—Jan. 12, "Recently Recognized Sexually-Transmitted Diseases." Thomas W. Mou, M. D.

Gassaway, Braxton Co. Memorial Hospital, 1st Wednesday, 7-9 P. M.—Jan. 5, "Evaluation & Management of Thyroid Nodules," Richard Kleinmann, M. D.

Feb. 2, "Yes, Virginia, There Are Venereal Diseases in Rural Practices," Patrick Robinson, M. D.

Welch, Stevens Clinic Hospital, 3rd Wednesday, 12 Noon-2 P.M.—March 16, "Protocols for Treating Poisonous Snake Bites," Edward Wright, M. D.

Buckhannon, Madison, Oak Hill, Whitesville, Williamson—(winter break in January).

Council Agenda Highlighted By Legislative Issues

The Medical Association's Council, acting on recommendations of the Committee on Legislation's steering subcommittee, has approved an ambitious program for the 1983 state legislative session to begin January 12.

Council directed preparation of eight bills, mostly in the area of so-called tort reform related to professional liability, and voted support of a measure to set up a simplified mechanism for obtaining corneas for transplant.

It left to the judgment of the leadership and the Committee on Legislation positions which might be taken on bills in the area of hospital rate setting and review, and hospital board composition, once staff has an opportunity to study measures actually introduced.

Bills Council directed prepared would:

Prohibit inclusion of a dollar amount in a malpractice claim; tighten the statute of limitations under which actions are brought; modify the collateral source rule which now prohibits evidence at trial of a patient's compensation from sources other than the defendant.

Payments for Future Damages

Mandate periodic payments for future damages; require juries to apportion damages among defendants; establish a fee schedule for attorneys' fees based on amounts of recovery; place a $250,000 maximum on recovery for pain and suffering, and other-economic losses; and provide by statute, with specific limitations, procedures through which patients could obtain copies or summaries of patient records.

In other action at its November 21 meeting, Council:

—Elected to honorary membership, after appropriate component society action, C. R. Davisson, M.D., of Weston; J. Carlton Godlove, M. D., Martinsburg, and Edward Gliserman, M. D., Holden in Logan County.

—Adopted a "mission statement" reiterating the Medical Association's commitment to continuing medical education, and particularly to its role as an accrediting arm of the national Accreditation Council for Continuing Medical Education (ACCME) with respect to such intrastate programs as those reviewed and approved at community hospitals.

—Approved for calendar and fiscal 1983 a Medical Association operating budget of $494,505, a figure only $599 above the budget for 1982.

—Approved a survey of State Medical Association members as to (1) whether they favor the concept of construction of an Association headquarters building on property now owned in Charleston; and (2) whether the members would be willing to purchase tax-exempt industrial revenue bonds issued by West Virginia State Medical Association Properties, Inc., to finance such construction.

—Approved expenditures of up to $4,500 a year from the Association's operating funds, as advances toward reimbursement, to cover properties corporation expenses such as taxes, audit costs and other minor items until that corporation has its own financial operating plan.

—Approved endorsement of a collection service offered by I.C. System, Inc., of St. Paul, Minnesota, with a proviso that funds accruing

Dr. Alex Wanger of Martinsburg, center, and Dr. William Wanger of Beckley were among participants at the recent 8th annual Hal Wanger Family Practice Conference at the West Virginia University Medical Center. The conference was named for their father, an early leader in continuing medical education in the state. The late Dr. Hal Wanger inaugurated the Potomac-Shenandoah Valley Postgraduate Institute, forerunner of the present conference. Chatting with the Doctors Wanger is Brita Nieland.

to the Medical Association as a result of the endorsement be to the benefit of the properties corporation.

—Re-elected Joe N. Jarrett, M.D., of Oak Hill to a new seven-year term on the Publication Committee, with the term to begin January 1, 1983.

—Endorsed TEL-MED, a library of taped telephone messages on a variety of health and health-related topics for the general public.

Association Committee Hears WVU Funding Review

The West Virginia University Medical School, troubled by some 1982-83 budget reductions, needs an additional legislative appropriation of $8 to $9 million for next year just to keep programs at 1981 levels, John E. Jones, M. D., has explained.

Doctor Jones, WVU's Vice President for Health Sciences, reviewed in detail the School of Medicine's budget request at a recent meeting of the State Medical Association's WVU Liaison Committee in Bridgeport.

He noted that WVU has no remaining "balance forward" funds in its account to carry it into the 1983-84 fiscal year, for which the Legislature to convene January 12 will have to fashion operating budgets for state departments, agencies and institutions. The Medical Center cut programs by $2.9 million in 1982-83.

A proposed two cents-a-bottle increase in the state's soft drinks tax—one source of funds for the medical school—could produce an additional $15 million a year, with half to be used for operational purposes and half for capital expenditures, Doctor Jones said.

Hospital Updating Needed

He explained that the aging West Virginia University Hospital will require expenditures of perhaps $30 million in the next few years to bring it in line with current fire, safety and other codes.

On a continuing somber note, Doctor Jones said that a faculty movement projection as of September 22, 1982, indicated a potential loss this school year of 44 physicians for a variety of reasons, including the salary structure and other feelings of instability.

Turning to the brighter side, Doctor Jones said WVU would be making significant new efforts to "tell its story better" as to the quality of its programs and graduates, and increased retention of physicians in West Virginia. The WVU School of Medicine was re-accredited in March for another four years, with an interim report set for 1985 a possible basis for a request for a further accreditation extension.

The Liaison Committee, chaired by James L. Bryant, M. D., of Clarksburg, commended Doctor Jones for authorship of a special article, "Financing of the West Virginia University School of Medicine," printed in the November, 1982, issue of *The Journal.*

'Selected' Providers Suggested By Health Task Force

Number one on a list of nine priority recommendations by a Health Cost Containment Task Force calls for legislation to create a state regulatory commission with authority to limit amounts hospitals charge patients.

Recommendation No. 2 proposes that hospitals and medical services provided by state funds be expended pursuant to "State procedures that provide a more cost-effective delivery of hospital and medical services."

In elaborating on the second recommendation, the final report by the Task Force—set up by Governor Rockefeller in September, 1981—provides some interesting reading. It says the

Review A Book

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication.

Current Obstetric and Gynecologic Diagnosis and Treatment, 4th Edition, edited by Ralph C. Benson, M. D. 1,038 pages. Price $25. Lange Medical Publications, Los Altos, California 94022. 1982.

Stand Tall!—The Informed Woman's Guide to Preventing Osteoporosis, by Morris Notelovitz, M. D., and Marsha Ware. 208 pages. Price $12.95. Triad Publishing Company, Inc., P. O. Box 13096, Gainesville, Florida 32604. 1982.

Basic and Clinical Pharmacology, by Bertram G. Katzung, M. D., Ph.D. 815 pages. Price $23.50. Lange Medical Publications, Los Altos, California 94022. 1982.

recommendation addresses the fact "that the State is contributing to the high cost of health care by permitting the free selection of hospitals by persons whose hospital and medical services are paid by the State." Here is further material from the report:

"This recommendation could be implemented by having the State select hospitals and medical providers that provide the most cost-effective services and authorizing payment for those services not to exceed the State-approved rate.

"For example, in areas of the State with two or more hospitals, the State could select the hospital providing the most cost-effective service and pay only the amount that hospital might charge, regardless of where the area residents might receive their services.

"If payments to hospitals and medical providers by the West Virginia Public Employees Insurance Board, the Welfare Department, the Workmen's Compensation Fund and all other State-funded health payment programs were made utilizing the rates of the most cost-effective provider(s) in the area where the patient resides, then a substantial saving would be made by the State.

"In addition, such a program would stimulate competition among providers to deliver the same quality service at the least cost."

The Task Force came up with 50 recommendations in all in the report made to the Governor and the Legislature shortly before December 1.

Houston Doctor Named WVU Medical Dean

Dr. Richard A. DeVaul, Associate Dean of the University of Texas Medical School at Houston, has been named Dean of the West Virginia University School of Medicine, it was learned as *The Journal* went to press.

Doctor DeVaul will assume his new position in the spring, said Dr. John E. Jones, WVU Vice President for Health Sciences.

Doctor DeVaul, 42, a native of Ames, Iowa, specializes in psychiatry. He received his M. D. degree from the University of Rochester, and did his psychiatric residency at Johns Hopkins University.

Doctor Jones said Doctor DeVaul "is a man of outstanding credentials."

Doctor DeVaul will succeed Dr. Robert H. Waldman, who was named Interim Dean after Doctor Jones was promoted to his current job last April.

At this writing, what bills for legislative consideration might be generated by the recommendations was not known, but a bill or bills to establish a hospital rate review and rate-setting commission seemed certain.

Similar legislation was tabled on the Senate floor in 1982, and not considered at the committee or other levels in the House.

Charleston Pediatrician Receives Award

Charleston pediatrician Henrietta Marquis, M. D., has become one of a handful of state residents to be honored as a Distinguished West Virginian.

She received the award on December 8 from Governor John D. Rockefeller IV during a surprise ceremony in Charleston at the Capitol Building on her 75th birthday.

Doctor Marquis specializes in child behavioral problems. She has practiced in Richwood, Beckley and Charleston during her career.

The award was created by Governor Rockefeller a few years ago. He praised Doctor Marquis for her many years of service to children in both the public and private sectors.

A native of Philadelphia, she moved to Richwood in 1935. In 1977, at the age of 70, she accepted a fellowship in child psychiatry at WVU Charleston Division. After studying for three years, she re-entered private practice. She also is a consultant for the adolescent unit of Lakin State Hospital.

Doctor Marquis received her undergraduate degree from Cornell University and her M. D. from the University of Pennsylvania.

She said she was overwhelmed by the award.

CME Program At Marshall Gets Accreditation

The Accreditation Council for Continuing Medical Education (ACCME) has granted four-year accreditation to the Marshall University School of Medicine.

Charles W. Jones, Ph.D., the school's Director of Continuing Medical Education, said the council looks at the administration, financial stability and educational integrity of programs, which can be accredited for periods of one to six years. Doctor Jones said the four-year period is standard.

"Accreditation by the ACCME indicates to the consumer that some national agency has re-

viewed the program and given its assurance that we know how to evaluate continuing medical education offerings and are able to screen them for quality," he added.

In the past year, the school's continuing medical education program has served health professionals from 41 West Virginia counties and 22 other states.

As a new medical school, Marshall previously had had a two-year provisional accreditation.

State Funds Needed To Keep Air Rescue Program

State funds totalling $3.73 million in 1983 are being sought for the full implementation of an air medical rescue program which was started on an experimental basis last July.

The West Virginia State Police MEDEVAC project, conducted in 26 counties during the pilot program, expires, along with its funding, this month.

The program was put together jointly by the West Virginia Department of Public Safety and the Office of Emergency Medical Services in the State Health Department. The two departments now are enlisting the aid of the medical community in securing the needed state money.

The program provides rapid transfer of critical patients from general care medical facilities to specialty care centers. Currently, the State Police Aviation Division has two Bell jet helicopters which are manned by three pilots, but missions are limited to daylight hours and minimum acceptable weather conditions.

27 Missions Completed

"To date there have been a total of 49 requests for this air support link to the Emergency Medical Service System, and 27 missions have been completed," said Samuel W. Channell, Associate Director of the Office of Emergency Medical Services. "We are finding that there is indeed a real need for this service, especially for critical patients in our more rural general hospitals."

In order to serve the entire state, the needs include: sufficient funds for the acquisition of two larger, twin-engine, all-weather helicopters; necessary ground support; and six State Police paramedics and six additional State Police pilots.

State Police Chief Fred Donohoe is scheduled to talk to physicians about the MEDEVAC program on Saturday, January 22, during the 16th Mid-Winter Clinical Conference in Charleston.

Medical Meetings

Jan. 10-12—Am. Society for Laser Medicine & Surgery, New Orleans.

Jan. 20-22—Neurosurgical Societies of the Virginias, Hot Springs, VA.

Jan. 21-23—16th Mid-Winter Clinical Conference, Charleston.

Jan. 29-Feb. 3—Am. College of Allergists, New Orleans.

Feb. 8-12—Am. College of Emergency Physicians, Surgery/Trauma, Detroit.

Feb. 11-13—Biomedical Topics in Psychiatry (Medical College of VA), Hot Springs, VA.

Feb. 18-20—Regional CME Meeting, Am. College of Physicians, Alexandria, VA.

March 4-6—Am. Medical Student Assoc., Cleevland.

March 10-15 — Am. Academy of Orthopedic Surgeons, Anaheim, CA.

March 20-24—Am. College of Cardiology, New Orleans.

March 25-26—Infection Control Workshop (Monongahela General Hospital, WVU School of Medicine), Morgantown.

April 15-17—WV Chapter, AAFP, Morgantown.

April 17-21—Am. Urological Assoc., Las Vegas.

April 17-22—Operative Treatment of Fractures & Nonunions (Johns Hopkins University), Hot Springs, VA.

April 18-22—Am. Roentgen Ray Society, Atlanta.

April 24-28—Am. Assoc. of Neurological Surgeons, Washington, D. C.

May 4-7—WV Chapter, Am. College of Surgeons, White Sulphur Springs.

May 8-12—Am. College of Obstetricians & Gynecologists, Atlanta.

May 13-14—Topics in Cardiovascular Diseases (Am. Heart Assoc.), Baltimore.

June 19-23—Annual Meeting of AMA House, Chicago.

Aug. 25-27—116th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

Sept. 29-Oct. 2—Am. Society of Internal Medicine, San Francisco.

Oct. 9-14—Am. College of Surgeons, Atlanta.

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WVU Medical Center
–News–

Compiled from material furnished by the Medical Center News Service, Morgantown, W. Va.

Prehistoric Gene Works 'Too Well' Today

Diabetes is often caused by a "thrifty" gene that in prehistoric times may have helped people survive but now tends to make them obese and subject to heart attacks.

Two WVU researchers, Drs. Margaret J. Albrink and Irma H. Ullrich, are conducting studies to determine the best kind of diet to combat the effects of this misguided gene.

"Diabetes is very strongly genetically determined," Doctor Albrink said. "Yet it is very common, especially the adult-onset variety or Type II. To be both common and genetic, it must have had survival value in past ages.

"The theory is that in those times food was scarce and a person might have to go for days without a meal. There would be survival value in having this thrifty gene to enable you not to spend too much energy, but to conserve it.

Result Obesity

"But when a creature who is genetically good at conserving energy is suddenly and regularly fed a lot, the result is obesity and the ailments that often go with it, including diabetes," she said.

Doctor Albrink, who is President of the West Virginia Affiliate of the American Diabetes Association, said one in every 20 Americans is believed to have diabetes, and that half of the cases are undiagnosed.

"Almost all individuals with undiagnosed diabetes are overweight adults with non-insulin-dependent or Type II diabetes," she said. "Diabetics are twice as prone to heart disease and stroke, and the disease, with its complications, is the third leading cause of death by disease in this country."

Doctor Ullrich noted that while Type-I "juvenile" diabetes requires insulin injections or pills to lower blood sugar, Type II diabetics "may actually be made worse by insulin treatment in some cases."

"The reason is that insulin is a fattening hormone, and weight loss is what many of these patients urgently need," she said.

In addition to the dietary studies being conducted by Doctors Albrink and Ullrich, WVU Medical Center researchers are working with other phases of diabetes. One of the most important involves gluconeogenesis, or how the body produces its own blood sugar.

Doctor Albrink said that more than a dozen Diabetes Association chapters around West Virginia observed Diabetes Month in November as part of a national observance. Runathons, bikathons and other fund-raising activities were held, with most of the money to be used for research and for patient and public education about diabetes, she said.

Dr. Stephen C. Rector, resident in medicine, and nurse Leah Heimbach examine an "accident victim" during the recent advanced life support trauma course at WVU Medical Center. The course, designed to teach emergency life-saving skills, was sponsored by the West Virginia Chapter of the American College of Surgeons. Persons portraying patients were made up by students from the WVU Department of Art.

New Harmarville program helps patients control and live with pain.

Harmarville Rehabilitation Center has assigned a special staff and 20-bed unit for the exclusive treatment of pain.

This program is achieving some dramatic results, particularly with back- and neck-injured patients. Over 90% of all pain program participants have shown improved physical functioning. For those patients whose goal was to return to work, over 50% achieved this goal. An additional 5% of our former patients are undertaking vocational training in preparation for employment.

Each pain patient is treated both in a group and individually, and the patient's family is deeply involved throughout the program. Treatment involves physical therapy, biofeedback and relaxation training, education and counseling, and vocational programming. Most important, our patients are taken off of all addicting drugs for pain.

For more information on Harmarville...its pain program and admission procedures, call John F. Delaney, M.D. or Mary Anne Murphy, Ph.D. at 781-5700.

Other special Harmarville programs:

- Neuro-spinal program for the rehabilitation of quadriplegics and paraplegics.
- Head injury program for cognitive retraining of brain-injured patients.
- Claims Assessment for Rehabilitation Evaluation and Services (CARES) for returning injured workers to maximum level of employment.

Harmarville Rehabilitation Center, P.O. Box 11460, Guys Run Road, Pittsburgh, PA 15238

Third-Party News, Views and Program Concerns

AMA Complains About Proposed Medicare Regulations

The American Medical Association recently urged Richard Schweiker, Secretary of the U. S. Department of Health and Human Services, to give his personal attention to proposed regulations that would alter Medicare reimbursement systems for physicians and interfere with contractual relationships between institutional providers and physicians. In a letter to the Secretary, AMA Executive Vice President James H. Sammons, M. D., said "many elements of the proposal are arbitrary and outside of the authorizing statute."

The regulations, proposed by the Health Care Financing Administration (HCFA) to implement Section 1887 of the Social Security Act, would establish criteria and maximum limits on reimbursement for physicians' services furnished to Medicare beneficiaries by "provider-based" physicians. The letter to Schweiker included the AMA's November 5 statement to HCFA calling for withdrawal of the proposed rules.

Statute Authorizations

The statute authorizes regulations to distinguish between physician services provided to individual patients and those services that are provided for the "general benefit . . . (of) patients in a hospital or a skilled nursing facility" for the purpose of allocating the cost of physician services between Medicare Part A and Part B. It also authorizes establishment of "reasonable compensation equivalents" that are to be applied as the maximum Medicare reimbursement for services furnished for the general benefit of the patient population.

In its statement, the AMA said the proposed regulations broaden the statute by extending reasonable compensation equivalents to Part B, whereas the law states that this system is to apply to professional services rendered for the general benefit of patients (Part A). The AMA said the rule would set limitations on anesthesiology and radiology services that are not authorized by law and would inappropriately deny Medicare reimbursement under Part B for clinical pathology services.

Compensation Fund Stresses Consultation Policy

Workmen's Compensation Commissioner Gretchen O. Lewis has called new attention to the Compensation Fund's policy regarding consultations requested by physicians. The policy first was set forth in *The Journal* in October, 1980.

The Fund continues to feel that the policy facilitates more timely medical care for injured workers; eliminates administrative paperwork and delay in the Fund as well as in doctors' offices; and permits, from the agency's viewpoint, better claims management.

The policy, set forth below, did not change a procedure stipulating that prior authorization be requested for a change of treating physician; treatment by other than the physician of record, and hospitalization/surgical intervention.

Here, again, is the material provided earlier:

NEW CONSULTATION POLICY

Effective November 1, 1980

If, in the opinion of the treating physician of record, a consultation (examination only) is deemed advisable in relation to the compensable injury, the treating physician may, without prior authorization, arrange the consultation, provided the consulting physician is located within 100 miles of the claimant's residence. However, the treating physician, upon arranging the consultation, must immediately notify the fund of the referral by narrative report outlining the claimant's condition and the reason a consultation is desired. It also is necessary that the consultant provide the Fund with a narrative report of the findings and recommendations.

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Obituaries

CLARK K. SLEETH, M. D.

Dr. Clark K. Sleeth, former Dean of the West Virginia University School of Medicine and a key figure in its development and growth, died on November 30 in a Morgantown hospital. He was 69.

Doctor Sleeth had been a member of the University faculty for more than 40 years. From 1961 until 1970, he served as Dean of the Medical School, which awarded its first doctorates in 1962.

After stepping down as Dean, Doctor Sleeth organized the University's Department of Family Practice in the early 1970s, and served as its Acting Chairman until 1973.

Doctor Sleeth, a member of the State Medical Association's Committee on Medical Scholarships since 1960, coordinated the scheduling of the Committee's annual interviews of beginning medical students for West Virginia medical school scholarships awarded each year by the Association. His service to the Committee continued beyond retirement in 1978 and included the 1982 meeting of the Committee last summer.

Born in Logansport, Marion County, Doctor Sleeth was graduated from WVU, and received his M. D. degree in 1938 from the University of Chicago. He took his internship and residency at the Henry Ford Hospital in Detroit.

He was a student of, and later a co-worker with, the late Dr. Edward J. Van Liere, considered the father of the four-year School of Medicine. He succeeded Doctor Van Liere as Dean.

During Doctor Sleeth's tenure, the School's graduating classes more than doubled, and it joined the ranks of leading centers for medical education and research.

As a physiologist and pathologist, Doctor Sleeth was author or co-author of some three dozen research papers.

A Professor Emeritus since his retirement, Doctor Sleeth continued working on several projects, including an updated history of the WVU Medical School faculty.

He was an honorary member of the Monongalia County Medical Society, West Virginia State Medical Association, and American Medical Association.

Doctor Sleeth was President of the Monongalia County Medical Society in 1951, and First Vice President of the State Medical Association in 1952.

Survivors include the widow; three daughters, Mrs. Hubert A. Shaffer, Jr., of Charlottesville, Virginia, Mrs. Jerry L. Creamer of Dallas and Mrs. David M. Fulton of Charleston, South Carolina; one sister, Mrs. Louis Hagan of Wheeling, and one brother, Charles R. Sleeth of Madison, New Jersy.

* * *

BERNARD ZIMMERMANN, M. D.

Dr. Bernard Zimmermann, who organized and for 13 years headed the Department of Surgery at the West Virginia University School of Medicine, died on December 4 in a Morgantown hospital. He was 61.

Doctor Zimmermann was the first person to be named chairman of a clinical department in preparation for the 1960 opening of University Hospital, which marked the actual beginning of WVU's four-year School of Medicine. He then was Professor of Surgery at the University of Minnesota Medical School.

In 1971, he was elected President of the Halsted Society, named for the father of modern surgical techniques and including some 150 leading educators in surgery and allied branches.

In 1973, Doctor Zimmermann resigned as Chairman of Surgery and returned to full-time teaching, research and operative surgery. The following year, an international group that included several of his former chief residents organized the Bernard Zimmermann Surgical Society, which sponsored lectures and prizes for outstanding students.

Doctor Zimmermann, a native of St. Paul, Minnesota, received both his undergraduate and M. D. (1945) degrees from Harvard University. He interned at Boston City Hospital and, in 1953, earned a Ph.D. degree (Doctor of Philosophy in Surgery) from the University of Minnesota.

A Navy veteran, he also was a member of the American Surgical Association, American College of Surgeons, National Society for Medical Research, Monongahela County Medical Society, and West Virginia State Medical Association.

In 1981, a portrait in tribute to Doctor Zimmermann was placed in the Medical Center.

Survivors include the widow; two sons, Bernard Zimmermann III of Swansea, Massachusetts, and Andrew Zimmermann of Somerville, Massachusetts; a sister, Mrs. Walter Limbach of Pittsburgh; and a cousin, Charlotte Nelson Smith of St. Paul.

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County Societies

CENTRAL WEST VIRGINIA

Dr. Harry Shannon of Parkersburg, President of the State Medical Association, addressed the meeting of the Central West Virginia Medical Society on October 28.

The meeting was held at the Bicentennial Motel in Buckhannon.

Other guests include Dr. Tom Stahly, a new radiologist from Summersville; Charles R. Lewis of Charleston, Executive Secretary of the State Medical Association, and Mrs. Richard S. (Linda) Kerr of Morgantown, President of the Auxiliary to the State Medical Association.

It was reported that the Cowen water supply has been fluoridated.

The Society elected new officers.—Joseph B. Reed, M. D., Secretary-Treasurer.

* * *

WESTERN

The Western Medical Society met on November 9 in Spencer at Roane General Hospital.

The guest speaker was Dr. Harry Shannon of Parkersburg, President of the State Medical Association.

Doctor Shannon gave a very interesting talk about involvement of individual members of the Medical Society in health care, and also discussed the present status of malpractice insurance and cases in West Virginia in comparison with other states. A question-and-answer period followed.

New officers were elected.—Ali H. Morad, M. D., Secretary-Treasurer.

* * *

McDOWELL

The McDowell County Medical Society met on November 10 at Stevens Clinic Hospital in Welch.

Following a pot-luck dinner arranged by the Auxiliary, there was a short presentation on domestic violence presented by Norman Googel and Associates from McDowell County.

It was reported that a poll of the Society was favorable for the support of an extended care facility in the County. The request for support had come from the Imperial Construction Company.

New officers were elected. — Muthusami Kuppusami, M. D., Secretary.

* * *

BOONE

The Boone County Medical Society met on November 30 at the Boone County Health Center, a new nursing home.

Officers for 1983 were elected, and three new members practicing in Madison were admitted.

The Society has chosen the second Tuesday of each month for its meeting date and continuing medical education.—Manuel T. Uy, M. D., Secretary-Treasurer.

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Metastatic Cancer Of Unknown Origin: Ohio Valley Medical Center Experience

GURIJALA N. REDDY, M. D.

Department of Radiation Oncology, Ohio Valley Medical Center, Inc., Wheeling, West Virginia; and Clinical Assistant Professor of Radiology, West Virginia University School of Medicine

One hundred and fifty-one patients with metastatic carcinoma from an unknown primary site were treated from 1969 to 1980 at Ohio Valley Medical Center (OVMC), Inc., Wheeling, West Virginia. Diagnosis, survival and prognosis of these patients are discussed.

Metastatic cancer of unknown origin is more frequently encountered in clinical practice than it was once believed. It constitutes 10 to 15 per cent of all cancer cases, and is a diagnostic and therapeutic challenge. Many articles have been published on the subject with reference to diagnosis and treatment, but the emphasis on investigating a patient with an occult primary cancer site is shifting from an aggressive to a conservative approach. It is evident from the literature that all types of metastatic cancer (different sites and histological varieties) with undetermined primary sites are not the same. For example, metastatic squamous carcinoma in the upper neck nodes should be worked up and treated differently from squamous or adenocarcinoma in the supraclavicular area or in the bone. The former usually has a better prognosis than the latter. Such patient material from OVMC is reviewed here with reference to survival, and a plea is made for judicious use of diagnostic methods. Because lymphomas constitute a different entity, they are excluded from this review.

Materials and Methods

OVMC Tumor Registry was searched for patients with metastatic carcinoma at single or multiple sites whose primary site could not be determined. There were 151 patients from 1969 to 1980 with histologically-proven diagnosis. In only five of these patients was histological diagnosis made at autopsy. Of the 151 patients, 89 were males and 62 were females. Ages ranged from 34 to 90 years, with a majority of patients being 60 or older. There were an additional 51 patients who would have been included in this study except for a lack of histological confirmation of diagnosis.

The presenting sites of metastatic cancer are listed in Table 1. The most common single site of mestastases was the lymph nodes, followed by the bone. Adenocarcinoma and undifferentiated carcinoma were the most common cell types as shown in Table 2. All patients had complete

TABLE 1

Presenting Site of Metastatic Cancer

Site	*No. of Patients*
Lymph Nodes	38
Bone	25
Abdomen	19
Liver	17
Brain	8
Lung	6
Generalized°	10
Other	28
TOTAL	151

° More than one site at diagnosis

TABLE 2
Histology

Type	*No. of Patients*
Squamous	25
Adeno Ca	44
Undiff. Ca	42
Unspecified Ca	31
Cytology	3
Other	6
TOTAL	151

histories recorded and physicial examinations performed. Their metastatic workups included a wide variety of hematological, biochemical, roentgenographic, isotopic, invasive and non-invasive x-ray studies as well as endoscopic examinations. In only a few of the patients could the primary site be determined.

Survival figures are rather grim; however, they are consistent with other published reports. Thirty per cent of these patients died within one month, and 80 per cent died within one year after the diagnosis was made. Only 20 per cent survived for one year or longer. The majority of the latter group were squamous carcinomas metastatic to upper neck nodes. These patients usually have a better prognosis than those with other metastases in other sites. Five patients were lost to follow-up and were counted as dead of cancer. Thirteen patients are alive at the time of this report.

Autopsy was performed on 13 patients. Of these, the primary site was found in only six—two lung and one each pancreas, ovary, kidney and rectum. In the remaining seven cases, the primary site of malignancy could not be determined.

Fifty-one other patients, 28 males and 23 females, with clinical and x-ray diagnosis but without histological confirmation, had equally poor or worse survival. Ninety per cent of these patients died within one year from the time of clinical diagnosis.

Adequate testing and appropriate treatment did not seem to influence the survival of these

TABLE 3
Mortality

	1 Month *No. of Patients*		*12 Months* *No. of Patients*	
With Histology	45/151	30%	121/151	80%
Without Histology	29/51	58%	46/ 51	90%

TABLE 4
Survival—Review of Literature

	Total No. Patients	*% Living*	*Time After Dx - Month*
Moertel *et al.*[1]	150	10	14
Stewart *et al.*[1]	87	12	12
Richardson *et al.*[2]	86	12	12
Reddy[2]	151	20	12

[1] Adeno Ca only
[2] All cell types (including neck node metastases)

patients. No attempt is made to analyze the investigations in detail.

Discussion

Many reports in the literature reveal that the survival of the patients with metastatic carcinoma whose primary site is unknown is poor (Table 4). Moertel *et al.*[1] from the Mayo Clinic reported 10-per cent survival at 14 months in 150 patients with metastatic adenocarcinoma of unknown origin treated with various chemotherapeutic agents. Richardson and Parker[2] reported 86 patients with unknown primary malignancy; 50 per cent died within three months and, by one year, 12 per cent remained alive.

Nystrom *et al.*[3] reported 266 patients with metastatic cancer from an occult primary site. An excellent review of diagnostic testing in this study revealed that only 8/218 (3.6 per cent) upper gastrointestinal tract contrast roentgenograms, 9/198 (4.5 per cent) full column barium enema examinations, and 5/187 (2.6 per cent) intravenous pyelograms were true positive results. This is a very low yield rate indeed. The authors also had many false positive results, and advocate use of these tests with specific organ dysfunction or clinical suspicion of abnormality.

Stewart *et al.*[4] from Sydney, Australia, reported 87 patients with malignancy from unknown primary site. The primary site could be determined in only eight patients after extensive workup. Median survival was 13 to 14 weeks. Only 12 per cent were alive at 12 months (estimated from graph). Because of the low yield rate and little influence on survival, they recommend fewer investigations as warranted by the individual patient's situation.

Steckel and Kagan[5] reported from the University of California, Los Angeles 253 patients with unknown primary site of malignancy initially. In 34 autopsies no primary site could be found in 20 cases and, of the remaining 14, seven patients had lung cancer. They com-

mented that "long and arduous diagnostic examinations may be pointless academic exercise."

Workup Not Rewarding

Based on the present survival figures and review of the literature, it is evident that extensive diagnostic workup is not likely to be rewarding in locating the primary cancer site. Even if it is located it will have little influence on the treatment (with very few exceptions) and on prolonging the survival of the patients. When approximately 90 per cent of these patients are expected to die of cancer within one year, putting them through expensive, time-consuming and uncomfortable diagnostic tests may not be justified.

By definition, metastatic disease in various sites, except in some neck nodes, is a stage IV disease which carries poor prognosis no matter where the primary is located. Metastasis is usually by hematogenous and, occasionally, lymphatic spread, suggesting generalized disease even though metastasis to only one site may be obvious at initial diagnosis. The majority of these patients are treatable by surgery, radiation therapy or chemotherapy, but are incurable.

By no means should any test that is likely to improve the patient's comfort and survival be withheld on the pretext of poor prognosis; however, blind and frantic search for primary location of cancer in every patient is discouraged. Patients do deserve special attention and adequate treatment, even for palliation, which should be highly individualized because of a wide variety of histological types and locations at initial diagnosis.

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To be engaged in opposing wrong affords but a slender guarantee for being right.

—William Gladstone

Epikeratophakia: A New Treatment For Corneal Irregularity And Keratoconus

THEODORE P. WERBLIN, M. D., Ph.D.
The Blaydes Foundation, Bluefield, West Virginia

The technique of epikeratophakia has been modified to treat corneal surface irregularity (astigmatism) and keratoconus. A lamellar corneal graft is sutured tightly in place atop the intact recipient cornea. The graft produces a flattening of the cornea and facilitates contact lens or spectacle correction of vision.

A case report of a keratoconus patient whose preoperative irregular astigmatism was eliminated and whose myopia was reduced 12 diopters is presented here. This procedure has much less morbidity than penetrating keratoplasty which is the usual treatment for advanced keratoconus.

To date, corneal graft rejection has not been encountered with this procedure.

ANTERIOR keratoconus is a noninflammatory axial ectasia of the cornea. It becomes recognizable at puberty and can progress relatively quickly or slowly with stabilization. Protrusion of the apex occurs because of thinning of the cornea. Clinically, this can be recognized by distortion of the curve of the lower lid caused by the corneal cone with the eye in down gaze (Munson's sign). Focal disruption of Bowman's layer causes the epithelium to be irregular in thickness and the basement membrane to be abnormal. When Descemet's membrane is stretched beyond its elastic breaking point, acute clouding of the cornea (hydrops) may occur. This increase in corneal clouding results from profound stromal edema.

Initial treatment includes the use of a hard contact lens to correct vision. This eliminates irregular corneal surface (astigmatism), but eventually contact lens fitting becomes impossible because this increasingly irregular corneal surface does not allow the lens to stabilize. Many cases of advanced keratoconus can be treated surgically with either penetrating or lamellar keratoplasty; however, penetrating keratoplasty may be impossible with large cones that extend to near the limbus. This form of surgery has the continual risk of graft rejection and cataract formation. Lamellar surgery is preferable because these risks are minimized or nonexistent. Previous forms of lamellar keratoplasty were extremely difficult because they required careful lamellar dissection over the surface of the cone.[1]

A new approach to the treatment of keratoconus has been developed by modifying the technique of epikeratophakia,[2,3,4] a form of lamellar refractive surgery. In this procedure, donor corneal tissue is lathed in the shape of a contact lens and sutured to the anterior surface of the recipient cornea. Any optical function which a contact lens can perform theoretically can be served by these lamellar grafts. For keratoconus, a plano lamellar graft (parallel surfaces) is sutured tightly in place to flatten the irregular corneal surface. The residual refractive error can be handled with either contact lenses or spectacles.

Case Report

A 33-year-old, white male had had poor vision for many years. He was first seen at The Blaydes Clinic in 1971, at which time he stated that the doctors in the military service had diagnosed keratoconus. His visual acuity was 20/50 OD and 20/200 OS, and his keratometer readings were 43.00 @ 180° x 41.30 @ 90° OD and 45.50 @ 180° x 42.00 @ 90° OS. Slit-lamp evaluation showed some central thinning in the right eye but no breaks in Bowman's membrane. However, a definite corneal irregularity in the left eye with a small amount of central corneal opacification and thinning was revealed. The cone was located in the infratemporal portion of the cornea.

Figure 1. Preoperative appearance of the cornea. The irregularity of the curve of the anterior corneal surface and a small apical scar can be seen.

The patient was informed that he might need a corneal transplant in the future but was advised to try hard contact lenses for the time being. The patient wore his contact lenses successfully for 10 years.

In May, 1981, an ulceration was discovered on the apex of the cone in his left eye. His visual acuity with contact lenses was 20/25 OD and 20/300 OS. The patient was then advised not to wear his contact lenses. He was treated medically, and the ulceration improved. The epikeratophakia procedure was explained to him when he was seen in June, 1981, because of his intolerance to contact lenses.

The patient's workup revealed the following findings: Vision (without correction) 20/80 OD, 20/300 OS; Vision (with spectacle correction) 20/30 OD, 20/200 OS; Vision (with contact lenses) 20/20 OD, 20/70 OS; Vision (with contact lenses and pinhole) 20/20 OD, 20/25 OS; Pachometry (stromal thickness) .51 mm OD, .43 mm OS and Tension 13 OD, 19 OS. His A-Scan readings were 24.57 OD, 24.78 OS, and his keratometry readings were 43.25 @ 75° x 44.25 @ 165° OD and 65.75 @ 20° x 53.00 @ 110° OS. Minimal apical scarring of the cornea was seen in the OS.

Graft Performed

The epikeratophakia lamellar graft was performed on the left eye on August 13, 1981 (Figure 1). In this procedure the epithelium was removed from the recipient cornea with absolute alcohol. A small amount of epithelium was left remaining in the periphery of the cornea. The peripheral cornea was trephined to a depth of 0.15 mm (8.0 mm in diameter), and the inner edge of the trephine cut excised to create a circular bed 0.5 mm wide and 0.15 mm deep. The exposed corneal stroma allows the graft to scar securely in place.

The lenticule (diameter 8.25 mm) was sutured to the recipient cornea (8.0-mm-diameter bed) using 20 multiple interrupted 10-0 nylon sutures. The graft was sutured under sufficient tension to flatten the central corneal cone. A plano bandage soft contact lens was used to cover the graft and protect the epithelium as it grows across the graft. At the time of surgery, the postoperative keratometry was 38.50 @ 55° x 43.75 @ 145°.

At three weeks, the corneal graft surface was completely covered with epithelium, and the bandage contact lens was removed. The donor corneal graft measured 0.2 mm thick, and the recipient measured 0.44 mm (Figure 2). All sutures were removed by three months postoperatively. At 13 weeks keratometry readings were 43.62 @ 21° x 49.62 @ 105°. Visual acuity was 20/200 without correction and 20/30 -1 with spectacle correction (-1.25 -3.50 x 120) (Figure 3).

Discussion

Penetrating keratoplasty is not always successful in the treatment of keratoconus, particularly in the case of extensive or displaced cones. Penetrating grafts are always subject to immune rejection. On the other hand, lamellar grafts, although safer, have not had the potential for producing 20/20 vision.[1] This is probably due to the extensive dissection of the recipient cornea and resultant interface scarring. In addition, the lamellar dissection is technically very difficult.

Epikeratophakia is a new form of lamellar refractive surgery which avoids this technical complexity. In the epikeratophakia procedure, the peripheral cornea is trephined to create a

Figure 2. Postoperative appearance of the lamellar graft at three weeks. A somewhat hazy appearance is characteristic of the early postoperative appearance of these grafts.

Figure 3. Three-month appearance of graft. By this time, all sutures have been removed and the graft has become quite clear.

circular bed. This trephine mark allows the graft to scar securely in place. The patient's cornea needs no other lamellar dissection. There is no manipulation of the thinned area of the cone, and the anterior chamber has no chance of being penetrated.

The epikeratophakia technique has been modified to produce flattening of the keratoconus cornea to facilitate contact lens or spectacle correction of vision. This is accomplished by suturing the plano lamellar graft tightly in place. These lamellar grafts do not seem to undergo immune rejection, and thus avoid this major complication of penetrating grafts. In addition, this technique has produced 20/20 visual acuity in keratoconus patients.[4]

Currently, keratoconus lamellar grafts are lathed with no refractive power. It is feasible that a microkeratome section could be used in place of lathed tissue. This would simplify the procedure. Donor tissue must be frozen in order to be cut on the cryolathe. This kills the keratocytes and makes the donor disk a nonviable tissue. Microkeratome sectioning would allow living tissue to be used. This may speed the visual recovery of the recipient eye.

Improves Three Major Problems

The treatment of keratoconus with epikeratophakia grafts was designed to improve the three major visual problems associated with this condition: myopia, regular astigmatism and irregular astigmatism. Postoperatively, the patient in this case study has shown less myopia and cylinder compared to preoperative values, and has lost the irregular astigmatism characteristic of keratoconus. The residual astigmatism and myopia also theoretically could be treated with these lamellar grafts. Experimental approaches to these complex optical problems currently are under investigation.

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Tension Pneumothorax During Anesthesia*

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Two cases of tension pneumothorax occurring shortly after the induction of general anesthesia are presented. Each complication was linked to the improper use of an accessory anesthetic ventilator valve known as the ventilator-mounted switch valve.

Tension penumothorax directly attributable to the improper attachment of the anesthesia circuit to a directional valve on the ventilator known as the "ventilator-mounted switch valve" has been described.[1] This device (Figure 1), however. still can be found on many anesthesia ventilators. and continues to be causative in the production of tension pneumothorax during anesthesia.

Case One

A 68-year-old female was scheduled for repair of a herniated lumbar disc. Her blood pressure was 138/80 mmHg, pulse 82/minute and respirations 16/minute. Anesthesia was induced using sodium pentothal. Succinylcholine was given to facilitate endotracheal intubation. An endotracheal tube was placed without difficulty, and breath sounds were found to be clear and equal bilaterally. Vital signs remained stable throughout the induction period. The patient subsequently was turned to the prone position on the operating table where her breath sounds were checked again and found to be normal.

The ventilator tubing was then accidentally connected to the ventilator-mounted switch valve post usually occupied by a reservoir bag. Tachycardia, hypotension, and subcutaneous emphysema occurred within the minute. The patient was immediately disconnected from the ventilator, and a loud rush of air was heard coming from the endotracheal tube. A chest x-ray showed a large pneumothorax, mediastinal shift, and subcutaneous emphysema (Figure 2). Chest tubes were placed and recovery was uneventful.

Case Two

A 52-kilogram, 16-year-old female was scheduled for an appendectomy. On arrival in the operating room she was afebrile, with a blood pressure of 126/80 mmHg, a pulse of 84 per minute and a respiratory rate of 14 per minute. She had no history of medical problems. Induction of anesthesia was uneventful. D-tubocurarine pre-treatment was followed by sodium pentothal 220 mg. and succinylcholine 80 mg. An endotracheal tube was inserted with ease. The breath sounds were clear and equal bilaterally prior to connecting the patient to the ventilator.

Shortly after the initiation of mechanical ventilation the surgeon complained that the blood

Figure 1. The ventilator-mounted switch valve with arrows indicating the internal channels.

*This paper was written while Doctor Pyles was a surgical resident at Marshall University School of Medicine, Huntington, West Virginia. Reprint requests may be directed to Doctor Pyles.

was dark. The chest was noted to be hyperinflated and motionless. The ventilator cycled as usual without corresponding chest wall movement. The endotracheal tube was disconnected from the circuit and a large volume of air rushed from the tube. One hundred-per cent oxygen was given by manual-assisted ventilation. Lung compliance was noted to be poor; however, vital signs were satisfactory with a blood pressure of 100/60 and a pulse of 100-110 per minute. Breath sounds were diminished on the right side. A recovery room chest x-ray demonstrated a 30-per cent penumothorax on the right. A chest tube was placed and recovery was uneventful.

Discussion

In a study by Cooper *et al.*,[2] 19.5 per cent of all anesthesia misadventures were categorized as "ventilator/breathing circuit" problems.

Each patient presented developed a tension pneumothorax secondary to the improper connection of the anesthesia circuit to the ventilator-mounted switch valve (Figures 3 and 4). The ventilators continued to cycle without delivering their volume to the patients and without audible changes in their operation. The lungs were overdistended to the point of rupture by anesthetic gases flowing directly into a patient's lungs through a closed system. Inadvertent build-up of pressure within the airway occurs when there is a continuous flow of anesthetic gases into the trachea with an obstruction to outflow. Modern anesthetic machines are capable of delivering pressures in excess of 4000 cm H_2O directly to the trachea when a cuffed endotracheal tube is in place.[3]

A medical device alert was distributed by Ohio Medical Products on December 8, 1981. In their letter they state, "AFTER CAREFUL REVIEW, WE STRONGLY URGE THAT THE USE OF THESE VALVES BE DISCONTINUED

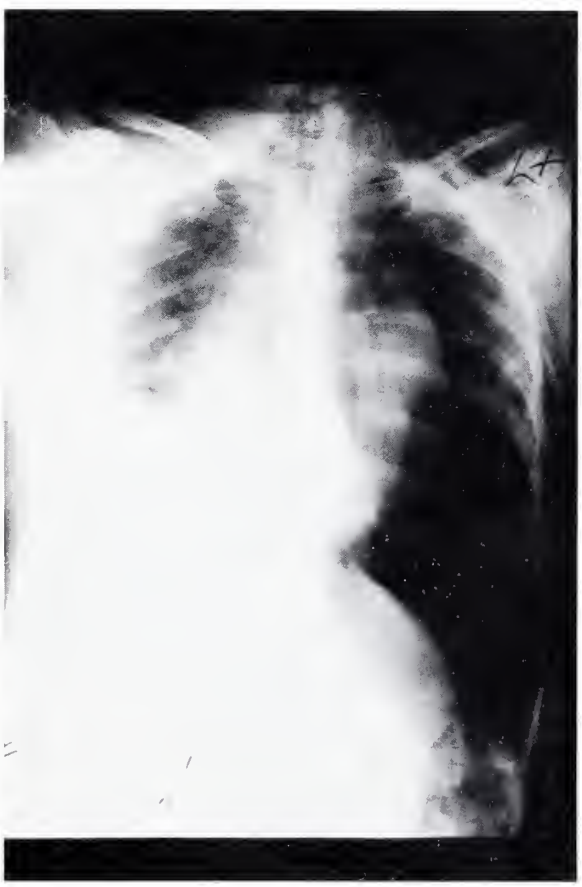

Figure 2. Patient number one. Portable post-induction chest x-ray in operating room. Note large left tension pneumothorax with mediastinal shift.

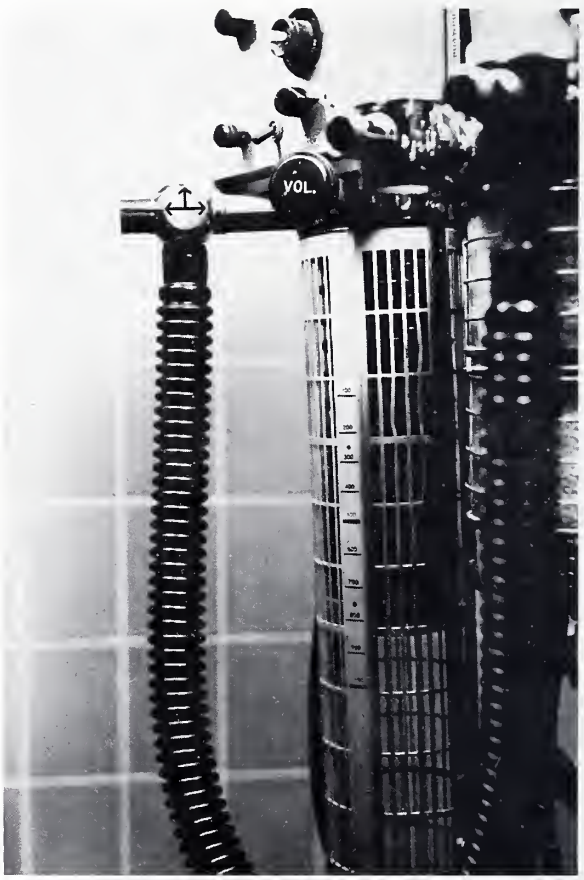

Figure 3. This photo demonstrates the ventilator tubing improperly attached at the reservoir bag port. Note that the stopcock is directed horizontally. In this situation gas flows from the anesthesia machine, fills the ventilator tubing and is blocked by the stopcock. Anesthetic gases continue to flow into the patient's lungs through a closed system, resulting in pneumothorax. The ventilator cycles normally, delivering its volume directly into the room through the open port.

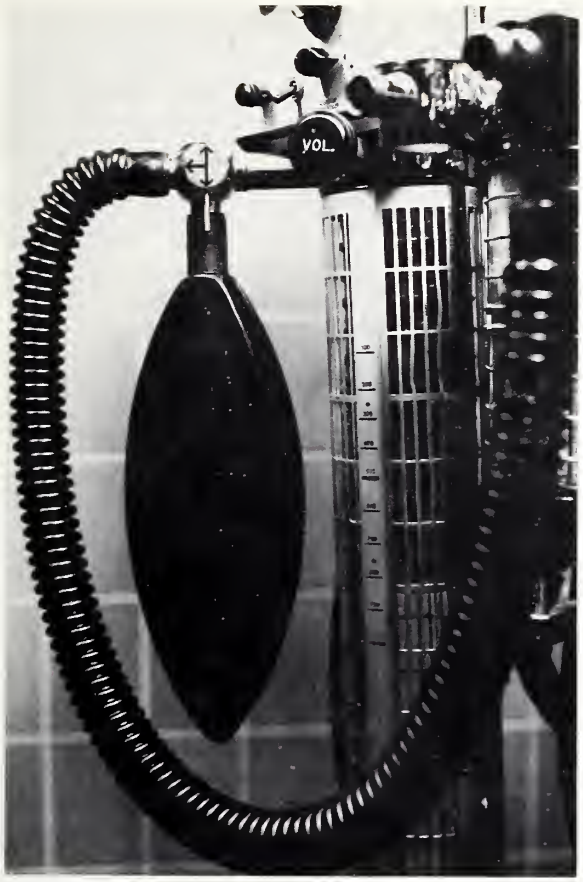

Figure 4. The ventilator-mounted switch valve shown with stopcock directed vertically. This position allows manual ventilation without disconnecting ventilator tubing. The vertical post is the bag port, and the horizontal post is the ventilator tubing port.

IMMEDIATELY AND THAT THESE VALVES BE PROMPTLY REMOVED FROM THE VENTILATORS AND DISPOSED OF IN A PROPER MANNER. WE SUGGEST STRIKING THE ENDS WITH A HEAVY OBJECT TO DEFORM, RENDERING THE VALVE INOPERATIVE."

Summary

Two cases of tension pneumothorax occurring during anesthesia are presented. These complications could have been prevented if either the ventilator-mounted switch valve had been used correctly or the breath sounds had been rechecked immediately after connecting the patient to the ventilator.

The anesthesia ventilator-mounted switch valve continues to be associated with anesthesia morbidity, specifically tension pneumothorax. The continued use of this device should be seriously questioned. We recommend immediate removal of the ventilator-mounted switch valve from all anesthesia ventilator systems.

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Medical Grand Rounds

From the West Virginia University Medical Center

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Relapsing Polychondritis

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Relapsing polychondritis, once thought to be a rare disease, is being reported with increasing frequency. It is a characteristic systemic disease which involves primarily cartilaginous tissue with an inflammatory and destructive process. It occurs equally in both sexes with a maximum frequency in the fourth decade. The most common clinical features are: bilateral auricular chrondritis, non-erosive sero-negative inflammatory polyarthritis, nasal chondritis, ocular inflammation, respiratory tract chondritis, and audiovestibular damage.

The diagnosis is based primarily on the clinical features with three or more of the above or one of the above plus histologic confirmation considered adequate. Fifty per cent present with auricular chondritis or the arthropathy. Laboratory and radiologic studies are of help mainly to rule out other possibilities. Corticosteroids are generally the drug of choice with recent reports of success with dapsone.

The mortality rate is reported from 22 per cent to 30 per cent with about half of the deaths due to respiratory involvement. Although the etiology is unknown, there is a frequent association with other rheumatic diseases. An autoimmune cause also is postulated.

Case Presentation

Doctor Cooley:

M.C. is a 64-year-old white male with a six-month history of weakness, fatigue, anorexia, a 15-pound weight loss and vague antero-lateral chest wall pain. He also complained of worsening dyspnea on exertion, orthopnea and pedal edema. Over the month prior to admission, he had noted nightly low-grade fevers not associated with chills. He was otherwise asymptomatic.

Physical examination on admission showed a cachectic, chronically-ill-appearing middle-aged male. Vital signs: BP of 100/60 mm Hg, pulse of 92, respiration of 30, and temperature of 36.8° C. The chest examination revealed dullness to percussion, decreased breath sounds and decreased tactile fremitus at both bases, diffusely scattered rhonchi and point tenderness over the left ribs. The cardiac examination was normal. The liver had a span of 14 cm.; the spleen was not palpable. Rectal examination showed heme negative stool. The lower extremities had 2+ edema. Neurological examination was remarkable only for depression and tearful affect.

Laboratories on admission: WBC was 10,100 with a normal differential; Hb, 9.3 gms; Hct, 28 per cent with normal indices; platelet count, 329,000; ESR, 126/hr; electrolytes, 12/60, CPK, and UA were within normal limits except for an alkaline phosphatase of 265 mu/ml; chest x-ray showed cardiomegaly, bilateral pleural effusions, emphysematous lung fields but no masses or infiltrates; and EKG showed left ventricular hypertrophy and left atrial hypertrophy.

Benign Transudate

Thoracentesis showed the pleural effusion to be a benign transudate. The patient was begun on oral digoxin and furosemide with the gradual resolution of his congestive heart failure. PPD was negative, with positive control skin tests. Multiple stools were hemetest negative. Iron studies were consistent with an anemia of chronic disease. A bone marrow biopsy was non-diagnostic, but showed no evidence of malignancy. Liver-spleen and bone scans were normal. Ultrasound of the abdomen and pelvis showed a questionable pelvic mass. CT scans of the chest, abdomen and pelvis were normal.

During his hospital course, the patient was noted to have evening temperature spikes to 38.5°C. A new, coarse systolic ejection murmur was noted at the lower left sternal border. 2-D echocardiogram demonstrated aortic regurgitation and a thickened tricuspid valve, with dense and shaggy echos suggestive of vegetations. Multiple blood cultures were without growth. The patient began to complain of polyarthralgias that had been plaguing him for months. Subsequently, he developed a migratory polyarthritis involving the right knee, right shoulder, left elbow and the left first metacarpophalangeal joint. Urethral, rectal and throat cultures were negative for gonorrhea. ANA and rheumatoid factor were negative.

Develops Episcleritis

The patient developed left episcleritis. One morning, he was found to have erythema, warmth, tenderness and boggy swelling over the bridge of his nose; this resolved within 48 hours. Subsequently, the patient developed erythema, warmth and swelling over the cartilaginous portion of his left ear; these findings resolved spontaneously within 24 hours. Given this constellation of symptoms, a presumptive diagnosis of relapsing polychondritis was made. He was begun on prednisone 10 mg. orally q.i.d. and discharged from the hospital. He remained asymptomatic but suffered Cushingoid side effects. The patient's prednisone was tapered. Subsequently, he developed a nasal chondritis and was started on dapsone. He has remained asymptomatic.

Discussion

Doctor Powers:

Relapsing polychondritis (RP) is a rare disease of unknown etiology which is being recognized with increasing frequency. Over 200 cases have been reported in the world literature to date, compared with 10 cases as of 1960. It is characterized by episodic, yet generally progressive, inflammation and degeneration of cartilaginous structures throughout the body, and recurrent inflammation of special sense organs including the eye and ear.

This syndrome was first described in 1923 when Jaksch-Wartenhorst[1] reported a 32-year-old brewery worker in Prague who initially had joint swelling and pain associated with fever. Later he developed in both external ears burning pain and swelling which, in three months, receded and shrank, leaving deformed pinnae, complete stenosis of both external auditory canals, decreased hearing, dizziness and tinnitus. He then developed a painless collapse of the middle segment of his nose, leaving a saddle deformity. Biopsy of the nasal septum showed "no cartilaginous matrix and hyperplastic mucosal membranes." During 18 months of followup there was progression of a peripheral arthritis with a tendency to deformity. Jaksch-Wartenhorst called this disorder polychondropathia.

In 1935, Altherr[2] and Von Meyenberg[3] separately reported the autopsy of a 14-year-old boy who had degeneration and destruction of the cartilage of his ears, nose, ribs, joints, larynx and tracheobronchial tree. They named the disorder chondromalacia. Bean, Drevets and Chapman[4] described one patient and summarized eight previous cases from the literature in 1958, and suggested the name of chronic atrophic polychondritis. Finally, Pearson, Kline and Newcomer,[5] in 1960, reviewed 10 previously reported cases and added four additional ones. They suggested the name "relapsing polychondritis," which is now generally accepted.

RP has been reported in all ages, but seems to fit a normal distribution with maximal frequency in the fourth decade. The average age of onset is 44. It is equally divided between the sexes. The majority of cases reported have been Caucasian; however, the disease has been seen in Asians, Hispanics and Blacks. It does not demonstrate a familial predisposition; however, there is one report of a pregnant woman with RP delivering a newborn who was similarly affected at birth. Another pregnant woman with RP reportedly delivered a normal newborn.

Clinical Presentation

In 1976, McAdam *et al.*[6] reported the results of a prospective study of 23 patients, and reviewed the world literature to establish the most common presenting symptoms of RP. These findings were further supported in a report of 10 cases from the Cleveland Clinic in 1979.[7]

Chondritis of the auricles and the arthritis of RP are the most common presenting manifesta-

tions, accounting for approximately one half of cases. The incidence of nasal chondritis, ocular inflammation and respiratory tract involvement is divided approximately equally, and accounts for the majority of remaining presentations. Patients presenting with audiovestibular symptoms and other miscellaneous syndromes make up the remaining small fraction.

Auricular chrondritis is typically bilateral, and presents as the sudden onset of marked redness, swelling, warmth and pain, limited to the cartilaginous portion of the external ears (helix, antihelix, tragus, and sometimes the external auditory canal). It is frequently described as having a violaceous hue. The ear is very tender to touch; the redness may include surrounding retroauricular soft tissues and may be accompanied by lymphadenopathy. An important point in the differential diagnosis is that the ear lobe, lacking cartilage, is always spared.

The inflammation usually subsides within 5-10 days but may last as long as four weeks. After a single prolonged attack or repeated shorter attacks, loss of cartilage in the ear results in the pinna becoming flabby and droopy; it may even flop up and down as the patient walks. These external ear changes are frequently referred to as "cauliflower ears."

Arthritis of RP

The arthritis of RP, the second most common presenting sign, is an inflammatory, oligo- or polyarthritis which tends to be asymmetric, and may involve the large and small joints of the upper extremity, hips, knees, ankles, occasionally the spine, and has a predilection for costochondral junctions, sterno-manubrial, or sternoclavicular joints. It is sero-negative and usually non-erosive. At the onset the pattern is often migratory, frequently associated with effusions, and can mimic closely rheumatoid arthritis or a spondylitic variant syndrome.

Occasionally the arthritis is monoarticular, very acute, and suggestive of infectious or crystal-induced arthritis. On x-ray there may be narrowing of the joint spaces or eburnation (degenerative conversion of bone or cartilage into a hard ivory-like mass with increased density on rotentgenograms as a result of inflammation), but usually no destruction.

RP also can develop in patients with preexisting chronic polyarthritis of various types (Reiter's syndrome, juvenile chronic polyarthritis, seronegative polyarthritis of the rheumatoid type).

The nasal chondritis often is of sudden onset, with the nose being very painful, red and inflamed. It may be associated with a feeling of tremendous fullness in the bridge of the nose and surrounding tissues, and occasionally mild epistaxis. After repeated bouts of inflammation, the nasal cartilage can collapse, forming the "saddle nose" deformity, but there have been reports of deformity without overt inflammation. In one patient the deformity developed overnight while asleep.

Ocular inflammation may involve almost every part of the eye and adnexal structures. The most common types of eye involvement are conjunctivitis, episcleritis, iritis and keratitis, with additional reports of cataracts, optic neuritis, extraocular muscle palsy, and exophthalmos. When ocular inflammation is the only presenting symptom, RP is unlikely and the differential diagnosis extensive.

Respiratory Tract Involvement

Respiratory tract involvement is a relatively unusual presenting feature of RP but is noteworthy because it represents critical and potentially lethal organ system involvement. The epiglottis, bronchial and thyroid cartilage may be involved. The patient may complain of tenderness over the trachea or larynx. Hoarseness, at times to the point of aphonia, is a common complaint. Some present with dyspnea, characterized as asthma-like, often with severe inspiratory stridor. Many have an associated cough, usually non-productive, rarely with minor hemoptysis.

Eleven of the 14 patients in McAdam's series who presented with respiratory complaints required a tracheostomy, and four eventually died with respiratory complications. The need for tracheostomy may be due to collapse of laryngeal or tracheal cartilage, or due to severe glottic, laryngeal, and subglottic inflammation and edema, leading to airway obstruction. Respiratory tract involvement is the main cause of death from RP, accounting for almost 50 per cent of the cases when the cause is known.

Unusual Manifestations

Another less common presenting symptom is middle or inner ear involvement manifested by sudden or gradual onset of unilateral or bilateral cochlear and/or vestibular nerve involvement. The symptoms of nausea, vomiting, vertigo, tinnitus and deafness may be transient or persistent. Conductive hearing loss due to serous otitis as a result of swelling of the eustachian tube cartilage may improve somewhat with resolution of the swelling and fluid. Sensorineural hearing impairment and vestibular dysfunction are pre-

sumed to be due to arteritis of the internal auditory artery or its vestibular branch.

Rarely, patients present with diffuse, severe, systemic symptoms of fever, anorexia, weight loss, arthralgias and myalgias, and represent diagnostic dilemmas until other more specific signs of RP appear.

The incidence of specific organ system involvement in 159 patients also was reported by McAdam.[6] The approximate order of occurrence was: 1) auricular chondritis, 89 per cent: 2) polyarthritis or other articular involvement, 81 per cent: 3) nasal chondritis, 72 per cent; 4) ocular inflammation, 65 per cent; 5) respiratory-tract chondritis, 56 per cent; and 6) audio-vestibular damage, 46 per cent. Less common are cardiovascular involvement, 24 per cent (valvular, nine per cent), and cutaneous lesions, 17 per cent. A frequent associated finding not included in McAdam's series is anemia (found in 10 per cent of Cleveland Clinic series.)[7]

The most common cardiac abnormality is aortic insufficiency. Heart failure, as a result, has on occasion responded to digoxin and furosamide but may require valve replacement. Hemodynamically, the most significant cardiovascular lesion results from the involvement of the ascending aorta and secondary dilatation of the aortic annulus leading to aortic regurgitation. The histopathological lesions in the aorta are due to medial involvement by the inflammatory process consisting of perivascular infiltration, increased vascularization and replacement of the elastic tissue by collagen tissue (similar to cystic medial necrosis).

Aortic Regurgitation

In the past, it was thought that aortic regurgitation in RP was secondary to dilatation of the aortic ring and not due to valve cusp involvement. Although thickening of the valve cusps was seen in a few instances, it was thought to be secondary to mechanical trauma produced by the regurgitation. However, in a case reported by Sohi *et al.* in 1981,[8] aortic cusp involvement by the inflammatory process, causing hemodynamic impairment without clinically and grossly obvious involvement of the ascending aorta or the aortic ring, was the first cardivascular abnormality. Pertinent to their finding is the fact that abnormalities in the composition (amino acids and lipids) of the aortic cusps were reported in 1971 by Alexander *et al.*[9] Other valvular abnormalities include a few reports of mitral insufficiency, with one report of a "floppy mitral valve" presenting simultaneously with RP.[10]

Additional cardiovascular abnormalities reported include a 25-per cent incidence of inflammatory vascular disease; aneurysm, thrombosis or vasculitis has occurred in the descending or abdominal aorta and in medium-sized arteries, subclavian, hepatic, superior mesenteric and peripheral arteries. Pericarditis, cardiac ischemia, arrhythmias, etc., have been reported but have not acquired significance in terms of frequency of occurrence.

Skin lesions also may be a feature of RP, and are thought possibly to reflect an underlying systemic vasculitis since the majority reported are vasculitic in nature. In addition to erythema nodosum-like lesions, there have been reports of retardation of nail growth, maculopapular eruptions, vesicular lesions and alopecia in one patient.

Diagnostic Criteria

With the frequencies of organ-system involvement in mind, McAdam empirically arrived at six proposed diagnostic criteria:[6]

1. Recurrent chondritis of both auricles
2. Non-erosive inflammatory arthritis
3. Chondritis of nasal cartilages
4. Inflammation of ocular structures including conjunctivitis, keratitis, scleritis/episcleritis and/or uveitis
5. Chondritis of the respiratory tract involving laryngeal and/or tracheal cartilages
6. Cochlear and/or vestibular damage manifest by neurosensory hearing loss, tinnitus, and/or vertigo.

McAdam felt that the diagnosis is based primarily upon the unique clinical features, and is quite certain if three or more criteria are present together with histologic confirmation.

In the 1979 report from the Cleveland Clinic, Damiani and Levine[7] proposed an expansion of the criteria for diagnosis of RP. They feel that a diagnosis of RP can be made when one or more of McAdam's signs are present along with positive histologic confirmation; the diagnosis also can be made when chondritis is present in two or more separate anatomic locations and there is response to steroids and/or dapsone. They based this proposal on the limited differential diagnosis of both the syndrome complex of RP and of three of the first five individual signs, namely auricular chondritis, nasal chondritis and laryngotracheal-bronchial chondritis. Diagnosis of RP based on these expanded criteria may lead to early diagnosis and arrest of the disease prior to manifestations of its other signs. Early diagnosis and treatment should be strongly encouraged in the

face of an illness with respiratory or cardiovascular involvement that carries a mortality of 22 per cent.

Pathology

Histologic examination of cartilage from a clinically involved site will confirm the underlying chondritis. The cartilage specimen may be obtained from the ear, nose or respiratory tract—keeping in mind that one does not want to produce any additional cosmetic deformities. The histologic changes of RP are easily recognized in florid form.

First, in a brief review of normal cartilage, the two basic components are the cellular (chondrocytes) and intercellular matrix (fibrillar elements and ground substance). The ground substance is composed of macromolecules called mucopolysaccharides and mucoproteins. The cartilage chondrocytes lie imbedded in the inter-cellular matrix. The matrix stains basophilic with hematoxylin and eosin and metachromatic with certain other stains.

In relapsing polychondritis, the primary abnormality appears to be in the mucopolysaccharide component of the ground substance, resulting in structural weakness. Light microscopy shows loss of basophilic staining of cartilage matrix, perichondral inflammation, and cartilage destruction with replacement by fibrous tissue. There is lacunar breakdown and infiltration of neutrophils: as inflammation continues, there is condensation into irregular whorls of collagen with plasma cells and lymphocytic infiltration. Chondrocytes dedifferentiate, forming fibroblasts and collagen fibers. Occasionally, small sites of cartilage regenerate. There is loss of matrix acid mucopolysaccharides, which results in the loss of basophilic staining. The primary change is loss of matrix acid mucopolysaccharides followed by a secondary perichondral inflammatory reaction.

The pathogenesis and etiology of RP are not clearly defined. However, the primary abnormality appears to lie in the dissolution of the mucopolysaccharide component of the ground substance by enzymatic proteolysis.

Experimental Models

Animal models using papain protease injected intravenously into young rabbits can produce rapid, diffuse depletion of cartilage matrix and collapse of the ears.[11] The same effect has been demonstrated with high doses of vitamin A, suggesting that vitamin A somehow activated proteolytic enzymes with similar properties to papain protease.[12] Barranco[13] treated rabbits with vitamin A and methylprednisolone or with vitamin A and dapsone and showed no collapse or dissolution of cartilage. Rabbits treated only with vitamin A showed collapse of cartilaginous components.

The cause of the proposed activation of proteolytic enzymes is not known. A hypersensitivity reaction has been suggested by Glynn and Holborrow,[14] who postulated that a bacteria or virus combined with chondroitin sulfate and protein in cartilage to form an antigenic substance. This would result in auto-antibody formation with antigen-antibody complexes activating complement, resulting in destruction of cartilage.

Immunological Abnormalities

Circulating anticartilage antibodies have been demonstrated by several investigators. An anticartilage antibody has been shown by direct immunofluorescence in a patient with RP.[15] In a 1981 report by Ebringer *et al.*[16] cartilage antibodies were demonstrated by indirect immunofluorescence on human fetal cartilage in six of nine patients with RP. The highest titers were present during the early acute phase of the disease.

Another 1981 report[17] demonstrated antibodies against rat costal cartilage in an RP patient's serum. Fiodart[18] demonstrated circulating antibodies to type II collagen during the acute phase of RP by indirect immunofluorescence after removal of proteoglycan.

The significance of these findings remains obscure as such antibody may be an accompaniment of cartilage destruction and not its cause. There also have been reports of cell-mediated immunity to cartilage.[19,20]

Co-existing Diseases

The co-existence of various rheumatic or "auto-immune" diseases noted in RP patients suggests a possible immunological mechanism underlying RP. The associated disease usually precedes the development of RP. McAdam divided the patients in his series into those with "pure" RP (about 75 per cent) and those with a co-existing rheumatic or autoimmune disease (about 25 per cent). Rheumatic diseases include rheumatoid and juvenile rheumatoid arthritis, Sjogren's syndrome, SLE, systemic sclerosis, Reiter's syndrome or psoriatic arthritis; the autoimmune diseases include thyroid disease (goiter, Hashimoto's thyroiditis or hyprothyroidism), ulcerative colitis, glomerulonephritis, dysgammaglobulinemias and non-caseating granulomas.

More recent reports include Wegener's granulomatosis, periarteritis nodosa, diabetes mellitus

with insulin resistance, vitiligo and antibodies to human intrinsic factor and gastric parietal cells. There has been a report of RP associated with carcinoma of the pancreas, and one report of RP preceding Hodgkin's disease by six months.

Differential Diagnosis

The differential diagnosis of RP may be extensive. If the auricular chondritis is bilateral, resolves spontaneously, and is recurrent, the differential diagnosis is almost exclusively limited to RP. Trauma or infection are other possibilities. However, infectious perichondritis is usually associated with fever, leukocytosis, regional adenopathy, clears with antibiotics, and initially may have been associated with trauma, mastoid surgery or chronic external otitis. The most frequent etiologic agent causing infectious perichondritis is Pseudomonas aeruginosa.

Calcification of cartilaginous structures of the ear as found in 40 per cent of patients with RP also has been reported in Addison's disease, ochronosis, acromegaly, essential hypertension, diabetes mellitus, hyperthyroidism and familial cold hypersensitivity.

Nasal chondritis also must be differentiated from infectious nasal perichondritis, which usually has positive cultures and responds to antibiotics. Nasal collapse resulting in saddle nose deformity also may be seen in congenital syphilis or Wegener's granulomatosis. A negative RPR and FTA-ABS, and lack of renal involvement, pulmonary parenchymal involvement or central or peripheral nerve involvement would help to rule out these respective diseases.

Other Similar Diseases

The articular manfestations of RP may be similar to rheumatoid arthritis, but RP-associated arthritis usually is not destructive and not associated with rheumatoid nodules or positive rheumatoid factor.

Reiter's syndrome resembles polychondritis because of the arthritis and eye lesions, but differs in that the urethral, dermal, and mucosal lesions commonly seen in Reiter's are not seen in RP.

Several entities have similar ocular inflammation, including Reiter's syndrome, rheumatoid arthritis, Still's disease, Behcet's disease, enteropathic arthritis, Wegener's granulomatosis, polyarteritis nodosa, Sjogren's syndrome (keratoconjunctivitis sicca and xerostomia), Cogan's syndrome (interstitial keratitis and vestibular auditory problems such as severe vertigo, tinnitus, ataxia and bilateral sensory neural deafness), syphilis, herpes zoster and entities with arteriosclerosis.

The differential diagnosis of laryngeal/tracheal/bronchial chondritis seen in RP is limited to infectious perichondritis, of which there could be many causes.

Laboratory Findings

The laboratory is only helpful in the diagnosis of RP when it serves to exclude other conditions. The only consistent findings are an elevated erythrocyte sedimentation rate during active disease, often with a moderate leukocytosis and mild-to-moderate anemia. The anemia is usually normochromic and normocytic with low serum iron and iron binding capacity (i.e., anemia of chronic disease).

Other laboratory findings tend to be nonspecific indicators of inflammatory disease. There have been a few cases of renal disease (specifically glomerulonephritis) associated with RP, but there was thought to be another active disease process to account for it. There have been reports of elevated liver function tests, but these are usually attributed to passive congestion due to heart failure.

Radiographic, findings includ calcification of the ears, nose and trachea: cardiovascular involvement with cardiomegaly or pulmonary congestion: or narrowing of joint spaces with eburnation. But most important is the use of radiology in evaluating the respiratory system. In addition to PA and lateral views of the chest, a PA and lateral soft-tissue view of the neck should be done to search for narrowing of the cervical trachea. Further delineation may be obtained by tracheal tomograms with or without radio contrast dye.

Therapy

Medical treatment of RP consists primarily of corticosteroids, immunosuppressive drugs and dapsone (diaminodiphenylsulfone). Salicylates, phenylbutazone, naprosyn and indomethacin have been tried and have been reported to be effective in some cases, but are not the drugs of choice. A number of cases responding to dapsone have been reported in the past six years.[13,21,22] It is theorized that dapsone functions in RP by inhibition of lysosomal enzyme release and thereby prevents chondrocyte damage. The range of dosage was 25 mg. to 200 mg. per day for one week to two years. The average dose was 75 mg. per day for four months. Side effects include lethargy, nausea, and hemolytic anemia (especially in G6PD deficiency). Serious rashes, agranulocytosis and aplastic anemia have been reported.

Steroids Drug of Choice

Steroids are probably still the drug of choice in treating RP—especially in the face of a life-threatening illness. Corticosteroids have been reported to be almost uniformly reliable in abating acute periods of activity, and in decreasing the frequency and severity of recurrences. They frequently are effective in laryngotracheal and external ear manifestations and in decreasing the sedimentation rate, but not always as helpful in the eye manifestations or in treating the sensorineural hearing loss.

The starting range is usually 30-60 mg. of prednisone per day with larger doses during periods of intense disease activity. The average daily maintenance dose is 20 mg. per day for a period of four months. Alternate-day therapy generally has been ineffective. When resolution of RP was seen, steroids were tapered, but there have been a number of cases that were never able to withdraw completely without an exacerbation.

In general, it is thought that the response to therapy is related to the aggressiveness of the disease. A number of patients that have not responded to steroids alone have been tried on immunosuppressive drugs (azothiaprine, cyclophosphamide, alkeran, methotrexate, plaquinil, nitrogen mustard and 6-mercaptopurine) with some success.

Surgical Treatment Limited

Surgical treatment of RP is limited. Tracheostomy may be necessary for respiratory distress secondary to tracheal/laryngeal/bronchial chondritis. Whether or not to treat the nasal collapse cosmetically is debated in the literature. with some reports of further deformity resulting. One point agreed upon is that no surgery should be attempted while the disease is in an active phase. Cardiovascular involvement may necessitate replacement of affected valves, or resection of aneurysms.

Prognosis

Mortality rates for RP are usually reported to be 22 per cent to 30 per cent after four to five years of disease. Almost half the deaths are due to respiratory involvement, mainly airway collapse. Other causes of death reported are pneumonia, ruptured aneurysm, vasculitis, cardiovascular (a few post-operative valve replacement), congestive heart failure, and malignancy. A more common prognosis for RP is a low-grade and smoldering course over many years with good control of symptoms with the use of corticosteroids.

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A message from . . .

The President

OUR LEGISLATIVE PROGRAM

By the time you read this the Legislature will be in session. Measures recommended by the Steering Committee of the Association's Committee on Legislation and approved for sponsorship by the Council are intended to provide a more rational and reasonable system for the trial or settlement of medical malpractice actions. When enacted, this system should help reduce the cost of liability insurance and thereby decrease the cost of medical care for all.

A brief summary of measures our Association has introduced include those to: (1) limit the statute of limitations to a more reasonable time frame; (2) introduce collateral sources of payments for damages; (3) determine reasonable and equitable contingency fees for attorneys; (4) eliminate demands for outlandish sums of money in claims; (5) establish reasonable limits to awards for non-economic loss; (6) establish degrees of liability proportionate to the degree of responsibility if more than one party is involved; (7) provide for periodic payment of damages so the award goes to the injured party; and (8) provide appropriate copies of records to be available to patients.

This legislation will *not* be a shield to protect MDs or to prohibit lawsuits for negligence. Anyone who has an injury from negligence is entitled to just, reasonable, and equitable compensation for it. The key words, though, are "just, reasonable, and equitable." A medical misadventure is not a reason to reap windfall profits for the patient or the attorney, any more than having an operation should be a reason for the patient to submit bills to three different insurance companies to profit from the illness.

The intent of our legislative program is to put a damper on unreasonable and exhorbitant awards, disproportionate to the injuries sustained, to plaintiffs and attorneys alike, *not* to deny reasonable, just and equitable compensation to those who have truly suffered injury. We must pass this measure on to our legislators, our patients and the public. If we do not, in the end all of us will pay the inflated cost.

In discussing these and other issues with several members of the Legislature, I have found them receptive and willing to listen. They appreciate knowing the facts, for these issues are clouded by emotion, and emotional issues are hard to deal with rationally and logically. The ball is in our court now. If you, the Membership, are not interested enough to initiate a discussion, make a phone call, or write a letter, we cannot expect the members of the Legislature to be interested enough to make the hard choices required of these emotion-laden issues. They want and need the information we can provide in order to make some hard decisions. It is the duty and responsibility of each one of us to do all he or she can to provide this information. We must not abdicate this responsibility.

Harry Shannon M.D.

Harry Shannon, M. D., *President*
West Virginia State Medical Association

The West Virginia Medical Journal

Editorials

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author shall be held entirely responsible. Editorials printed in The Journal do not necessarily reflect the official position of the West Virginia State Medical Association.

PRIORITY GOOF

Among 50 recommendations given the Governor and the Legislature by the state's Health Cost Containment Task Force was one calling for creation of another such study group in the general area of malpractice insurance.

In summary, the recommendation called for a task force, with members knowledgeable about insurance, law and medicine, "to specifically consider insurance and tort law reforms for the resolution of complaints of medical and hospital malpractice."

But when the cost containment task force was putting its final report together, and ranking in order of priority various recommendations under the so-called "hospital/medical" group, it placed the malpractice problem issue 11th on a list of 12.

State Attorney General Chauncey Browning, who chaired the health care cost study unit created by Governor Rockefeller on September 28, 1981, explained that the task force—which held 13 monthly meetings over a period of more than a year—simply did not have time to study this particular issue.

To some, that wasn't a very adequate answer. Browning himself earlier had commented that there was no group in West Virginia "that knows more about the health care cost situation than this Task Force." That being the case, how did the growing professional liability problem fall down the crack? The force's final report indicated that it didn't—at least, not entirely.

"It was brought to the attention of the Task Force that malpractice insurance for hospitals and physicians is an expenditure that increases the costs of health care," the report noted. "Due to their specialty, some physicians pay more than $20,000 per year for malpractice insurance." The report continued:

"In addition, it is said that many laboratory tests and x-rays are routinely ordered merely for malpractice prevention rather than because there is any reasonable need for the services."

Then came the observation that "this Task Force has considered many areas, and has not had the time to concentrate upon the malpractice area to the extent necessary to develop a recommendation that would propose a solution to the problem."

Accordingly, "This Task Force recommends the appointment of another group to specifically consider the malpractice problem."

A lack of time by the health care cost study group to consider this particular issue now is the proverbial water over the dam. But how a Task Force that considered itself as most knowledgeable about health care costs could rank the professional liability problem No. 11 on a list of 12 items must remain somewhat of a mystery.

Maybe, in all of its work, the group didn't have time to read a newspaper every now and then. That's really all that would have been necessary to get some inkling of the scope of the difficulty.

CLARK KENDALL SLEETH, 1913-1982

We will be a long time getting over missing Clark Sleeth. Much will be said and written about our gentle contemporary. Especially will those who matured under his wise direction in the School of Medicine try to express his worth to them, and be unable to put their thoughts into words that mean what they feel about Clark. Even more so do we, his equals in time, find it hard to say what our hearts are shouting inside as we keep missing him. There is a great urge to pay him tribute by way of the written word. And so we surrender to it, knowing full well the effort will not say it adequately.

When we first knew him as assistant in Doctor Van Liere's physiology department in the old medical school—we of the last great class of 84 souls to be admitted to the old school — his always friendly mien and his concern were like soothing unguent to our eroding egos as we struggled to stay afloat in the first year's un-

certain seas. And it's hard to separate that Clark from the one we have known in recent years, for he has never changed from the always dignified but cheerful and witty, friendly and encouraging helper of all who came to him for support. And he has shared those benefits with countless patients as he has practiced the art of healing with the same intensity which was part of his every endeavor.

We will leave to others the telling of his scientific, scholastic and administrative talents which so notably served the need of our University Medical Center. For example, the Department of Family Practice will pay him tribute for its existence, and for being perhaps the most effective among the host of determined and hard-working family doctors who for years had been pushing for its founding. But those are not the things we miss about Clark, for the torch of these responsibilities passed smoothly from his wearying hands to other capable ones.

So it's pretty hard to pinpoint the why about our missing Clark. We have wonderful Nellie to call on and talk to, and everything she is has a lot to do with our missing him. It's just hard to say. But we will take a long time to get over missing Clark Sleeth. And maybe we never will. —JNJ

GOLD RUSH

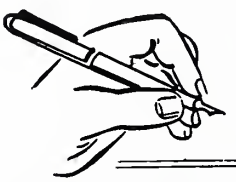
As indicated in *The Journal's* January issue, several so-called tort reform bills are a part of the State Medical Association's 1983 legislative program. In that light, the following comments by Charles D. Hollis, Jr., M. D., President of the Medical Association of Georgia, not only are interesting, but call new attention to some key components of the liability insurance dilemma. Here's Doctor Hollis:

"The alarming escalation of frequency and severity of malpractice claims is not just a problem facing hospitals and physicians. The staggering sums of money awarded must ultimately come from patients, thus becoming a significant factor in the increase in all medical costs. But the awarded monies are only the tip of the iceberg. Otherwise unnecessary tests, x-rays, and hospitalizations ordered as a protection against medical malpractice claims increase utilization and constitute as much as an estimated 30 per cent of the total health care expenditures. This is 30 per cent of the $300 billion spent on health care services annually in this country. From a personal perspective, I believe that these estimates are realistic.

"Thus, in the professional liability fiasco, we are dealing with a social problem, not just with a medical economics problem. It is of such magnitude that we are compelled to take legislative action to offer relief to the public. We must look to our friends in the Legislature to find meaningful and constitutionally sound tort reform laws.

"It won't be easy. The plaintiff bar has to consider the hundreds of millions of dollars in contingency fees and will thus oppose any effort to improve the professional liability insurance climate. But, I believe it is possible — if we teach the business community and our patients what is involved. A well planned and coordinated effort will be necessary. Indiana has implemented model tort reform legislation which has withstood challenges in the courts. As a consequence, Indiana physicians and patients have been spared the apprehension, frustration, and expenses faced by physicians, hospitals, and their patients in most states.

"The public welfare is involved. As concerned physicians, we cannot afford to allow the gold rush by the plaintiff bar to block efforts now to effectuate meaningful tort reform."



Our Readers Speak

Violation of Ethics

On April 15, 1982, in Indianapolis, Indiana, an innocent, defenseless newborn human being was killed (murdered) by starvation and dehydration with the sanction of the courts. Infant Doe was not only refused surgical care to correct an esophageal-tracheal fistula, but had fluids and food withheld until the baby died six days later. Why was this allowed to happen? Because he was something less than "normal." He had Down's Syndrome.

Where is the blame to be put for such a blatant act? Surely the parents must be blamed for being unwilling to accept their responsibility. Certainly the courts must accept blame. To me, however, the most blame must lie with the doctor who, by doing what he did, no matter at whose insistence, violated every principle of medical ethics. A doctor's responsibility is always to attempt to cure, not to kill. What a precedent this could set—accepting killing as an acceptable mode of treatment.

I have seen this case reported in medical literature but I have not seen it condemned in medical literature. Has the abortion (killing) ethic so inured us that such actions are now acceptable? Even if the courts declare such conduct to be legal, should the medical profession blindly follow? I hope and pray not!

Clarence H. Boso, M. D.
Huntington, WV

GENERAL NEWS

Program For Annual Meeting Begins To Take Shape

Two general scientific programs featuring symposia on sexually transmitted and cardiovascular diseases will feature the West Virginia State Medical Association's 116th Annual Meeting August 25-27.

The convention at the Greenbrier in White Sulphur Springs will get under way with the usual Council meeting on Thursday morning, August 25, and the first House of Delegates session that afternoon.

David Z. Morgan, M. D.

Frank J. Jirka, Jr., M. D., Chicago area urologist who will take office in June as the American Medical Association President, has been invited to address the first House meeting.

The initial general scientific session at 9:45 A.M. on Friday, August 26, will be preceded by the traditional opening exercises. A keynote speaker for that program will be announced later.

David Z. Morgan, M. D., of Morgantown, the Annual Meeting Program Committee Chairman, said the symposium on sexually transmitted diseases Friday morning will include papers on these individual topics:

Syphilis and gonococcal infections; non-luetic, non-gonococcal venereal diseases; transmissible diseases of the gay patient, and sexual mores in the 1980s.

The Program Committee will announce later speakers for this symposium, as well as for the cardiovascular disease program on Saturday morning, August 27, and upcoming issues of *The Journal* will provide such details.

Saturday morning topics will include new developments in the management of cardiac arrythmias; an update relative to cardiovascular surgery, and the management of congestive heart failure.

Specialty Meetings Planned

In addition to the general sessions, the Annual Meeting agenda will include breakfast, luncheon and other programs arranged by specialty societies and sections, many of which also will provide scientific discussions.

The specialty group meetings will be held in large measure on Friday, with a few to be set for Saturday morning, preceding the second general session, and at noon.

The House of Delegates will hold its second and final session on Saturday afternoon, at which time Carl R. Adkins, M. D., of Oak Hill will be installed as the Association's 1983-84 President to succeed Harry Shannon, M. D., of Parkersburg.

Continuing a practice of many years, the Auxiliary to the State Medical Association, with Mrs. Richard S. Kerr of Morgantown the current President, will hold its meeting in conjunction with that of the Association.

Others serving with Doctor Morgan on the 1983 Program Committee are Doctor Adkins; Jean P. Cavender, M. D., Charleston; Michael J. Lewis, M. D., St. Marys; Kenneth Scher, M. D., Huntington, and Roland J. Weisser, Jr., M. D., Morgantown.

Reservation forms provided by the Greenbrier were mailed to Association members with Executive Secretary Charles R. Lewis' annual bulletin early in January.

The membership is urged to give the matter of reservations its earliest possible attention. If forms for some reason did not reach physicians, others may be obtained from the Association's headquarters office, P. O. Box 1031, Charleston 25324.

Congress' Lame Duck Session Leaves AMA-FTC Deadlock

The American Medical Association and Federal Trade Commission fought to a standstill in the lame duck session of Congress, with the final version of the continuing resolution funding various agencies of government until early this

year omitting any mention of the FTC's having, or not having, jurisdiction over the professions.

That leaves the situation where it was two years ago, but AMA lobbyists did succeed in removing the language of the Rudman Amendment, which was adopted by a vote of 15-14 by the Senate Appropriations Committee.

The Rudman Amendment prevailed when the Chairman, Senator Mark Hatfield, Oregon Republican, was called upon to break a 14-14 tie.

The Senate tabled, or killed, by a 59-37 vote, the proposal that would have prevented the FTC from investigating or taking action against medicine or other state-regulated professions.

At 6 A. M. the morning of December 16, the House adopted the language of the Rudman Amendment (similar to the Broyhill Amendment) giving FTC jurisdiction over the professions.

AMA lobbyists went to work to prevent the adoption of this language, which would have established FTC's jurisdiction. The result of that effort was the expunging of the Rudman language from the continuing resolution, leaving the long controversy right where it was.

The AMA bill, to remove any doubt of FTC jurisdiction over the state-regulated professions, will have to be introduced in the new Congress, which convened in January.

In the meantime, the regulatory agency's authority over medicine is now the law of only the Second Circuit, not the law of the land.

The 4-4 U. S. Supreme Court decision, which gave no opinion and thus set no precedent, merely let stand the decision in that circuit.

Review A Book

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication.

Current Obstetric and Gynecologic Diagnosis and Treatment, 4th Edition, edited by Ralph C. Benson, M. D. 1,038 pages. Price $25. Lange Medical Publications, Los Altos, California 94022. 1982.

Basic and Clinical Pharmacology, by Bertram G. Katzung, M. D., Ph.D. 815 pages. Price $23.50. Lange Medical Publications, Los Altos, California 94022. 1982.

Nine Months' Reading: A Medical Guide for Pregnant Women, 3rd Edition, by Robert E. Hall, M. D. 178 pages. Price $13.95. Doubleday & Company, Inc., 245 Park Avenue, New York, New York 10167. 1983.

Family Physicians' Meeting Scheduled In April

"Physician, Heal Thyself" will be the theme for the opening session of the 31st annual scientific assembly of the West Virginia Chapter, American Academy of Family Physicians, to be held April 15-17.

Gordon H. Deckert, M. D.

Donald L. Cooper, M. D.

The meeting site will be the Lakeview Inn and Country Club in Morgantown, with the first session to begin Friday morning, April 15.

Some 15 physicians and others will make up the faculty for the scientific sessions which, in addition to the Friday morning session, will be held Friday afternoon, Saturday morning and afternoon, and Sunday morning.

The opening session will be presented in two parts, "Physician, Know Thyself" and "Physician, Understand Thyself," by Gordon H. Deckert, M. D., and Jane Chew Deckert, B. D., M. S. Doctor Deckert is Professor and Head, Department of Psychiatry and Behavioral Sciences, University of Oklahoma College of Medicine, Oklahoma City. Presentation techniques will include dramatization and structured group exercises.

The Assembly program is acceptable for 18 and one-half Prescribed hours by the AAFP, and is approved for the same number of hours

Donald S. Robinson, M. D.

G. J. Brodmerkel, Jr., M. D.

in Category 1 of the Physician's Recognition Award of the American Medical Association.

Family physicians will be welcomed to the scientific assembly by Dr. Robert D. Hess of Clarksburg, President. Opening remarks will be made by Drs. Arlo P. Brooks, Jr., of Parkersburg, President Elect and Program Chairman, and Harry Shannon, also of Parkersburg, President of the State Medical Association.

Other Speakers

Other speakers and their topics will be:

Friday Afternoon: "What Is Your Fitness?" — Donald L. Cooper, M. D., Director, Student Health Center, Oklahoma State University; "Dealing with the Impaired Physician" — Perry R. Ayers, M. D., Clinical Professor, Department of Preventative Medicine, Harding Hospital, Worthington, Ohio; and "Office Management of Family Physicians' Practices" — David C. Scroggins, M.B.A., C.P.B.C., Clayton L. Scroggins Associates, Inc., Cincinnati.

Saturday Morning: "Diagnosis and Treatment of Sleep Disorders"; "Respiratory Impairment in Sleep — Clinical Manifestations, Diagnosis and Current Treatment Approaches" — Helmut S. Schmidt, M. D., Director, Sleep Disorders Evaluation Center, Ohio State University, Department of Psychiatry, Columbus; "Now I Lay Me Down to Sleep . . . Insomnia" — Thomas Roth, Ph.D., Director, Sleep Disorders and Research Center, Henry Ford Hospital, Detroit; and "Pharmacology and Therapeutics of Hypnotic Drugs" — Donald S. Robinson, M. D., Chairman and Professor, Department of Pharmacology, and Professor of Medicine, Marshall University.

Saturday Afternoon: "Peptic Ulcer Disease" — George J. Brodmerkel, Jr., M. D., Head, Division of Gastroenterology, Department of Medicine, Allegheny General Hospital, Pittsburgh; "Treatment of Low Back Pain" — Gerald R. Gehringer, M. D., Professor and Head, Department of Family Medicine, Louisiana State University, New Orleans; and national President, AAFP; "Hypertension Treatment for Family Physicians" — Joseph M. Pitone, D.O., Assistant Professor of Medicine, Department of Nephrology and Hypertension, University of Medicine and Dentistry of New Jersey, New Jersey School of Osteopathic Medicine; and Head, Subsection, Department of Nephrology and Hypertension, John F. Kennedy Memorial Hospital, Stratford (New Jersey) Division; and "A Recent Update on Beta Blockers" — Wayne A. Border, M. D., Chief of Nephrology, University of Utah, Salt Lake City.

Headaches in Children

Sunday Morning: "Recent Advances in Treatment of Headaches in Children" — Arnold D. Rothner, M. D., Chief, Section of Child Neurology, The Cleveland Clinic Foundation; "The Use of Thrombolytic Therapy in Venous Thromboembolic Disease" — Ronald N. Rubin, M. D., Director, Oncology Unit, and Assistant Professor of Medicine, Temple University Hospital; "New Concepts in Rheumatology" — Steven Abramson, M. D., Assistant Professor of Medicine, New York University Medical Center, New York City; and "Senile Dementia"—James T. Hartford, M. D., Associate Professor and Chief, Geriatric Psychiatry, University of Cincinnati.

Additional meeting details are scheduled to appear in the March issue of *The Journal*. Meanwhile, registration and other information may be obtained by calling (304) 776-1178.

David J. Fine Named To Fill WVU Hospital Post

David J. Fine, Senior Associate Director of the University of Nebraska Hospital and Clinic at Omaha, has been appointed Administrator of West Virginia University Hospital.

John E. Jones, M. D., WVU Vice-President for Health Sciences, said Fine assumed his new duties in January on a part-time basis and would be full-time within three months.

He succeeds Eugene L. Staples who resigned to become director of the University of Kansas Medical Center hospital last June. Associate Administrator Bernard G. Westfall has been serving in the interim.

Fine, 32, was born in Flushing, New York, and is a graduate of Tufts University and the University of Minnesota.

Continuing Education Activities

Here are the continuing medical education activities listed primarily by the West Virginia University School of Medicine for part of 1983, as compiled by Dr. Robert L. Smith, Assistant Dean for Continuing Education, and J. Zeb Wright, Ph. D., Coordinator, Continuing Education, Department of Community Medicine, Charleston Division. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of The Journal.)

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the Morgantown, Charleston and Wheeling campuses. Further information about these may be obtained from: Division of Continuing Education, WVU Medical Center, 3110 MacCorkle Avenue, S. E., Charleston 25304; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 2000 Eoff Street, Wheeling 26003.

Feb. 6-9, Snowshoe, Surgical Conference

March 18, Charleston, 10th Annual Newborn Day

March 25-26, Morgantown, Infection Control Workshop

March 28-29, White Sulphur Springs, Symposium on Tumors for the Orthopedic Surgeon

April 28, Wheeling, Balance Disorders

April 29, Charleston, Research Day

April 29-30, Morgantown, Orthopedic Reunion Days

May 7, Charleston, Outpatient Infectious Diseases

May 12-13, Morgantown, Health Officers Conference

Regularly Scheduled Continuing Education Outreach Programs from WVU Medical Center/ Charleston Division

Buckhannon, St. Joseph's Hospital, first-floor cafeteria, 3rd Thursday, 7-9 P. M. — Feb. (winter break)

March 17, "Thyroid Dysfunction: Diagnosis and Management," Richard Kleinmann, M. D. April 21, "Prenatal Disorders and Congenital Anomalies," R. Stephen S. Amato, M. D.

Cabin Creek, Cabin Creek Medical Center, Dawes, 2nd Wednesday, 8-10 A. M.—Feb. 9, "Evaluation and Treatment of Burns," Augusto Portillo, M. D.

March 9, "Overall Outpatient Management of Renal Dysfunctions," Mary Lou Lewis, M. D.

Gassaway, Braxton Co. Memorial Hospital, 1st Wednesday, 7-9 P. M.—Feb. 2, "Yes, Virginia, There Are Venereal Diseases in Rural Practices," Patrick Robinson, M. D.

March 2, "Enteral Alimentation," Brittain McJunkin, M. D.

April 6, "Clinical Intervention in Drug & Alcohol Abuse." Thomas Haymond, M. D.

Madison, 2nd floor, Lick Creek Social Services Bldg., 2nd Tuesday, 7-9 P. M.—Feb. (winter break).

March 8, "Drug & Alcohol Abuse: Intervention Strategies," Thomas Haymond, M. D.

Oak Hill, Oak Hill High School (Oyler Exit, N 19) 4th Tuesday, 7-9 P. M.—Feb. (winter break).

March 22, "End-Stage Renal Disease," Mary Lou Lewis, M. D.

April 26, "Adolescent Sexuality: Recognizing & Treating Pathological Behavior," T. O. Dickey, M. D.

Welch, Stevens Clinic Hospital, 3rd Wednesday, 12 Noon-2 P. M.—Feb. (winter break).

March 16, "Protocols for Treating Poisonous Snake Bites," David O. Wright, M. D.

Whitesville, Raleigh-Boone Medical Center, 4th Wednesday, 11 A. M.-1 P. M.—Feb. (winter break).

March 23, "Hypertension Update: Diagnosis & Management." Stephen Grubb, M. D.

April 27, "Obesity: Emotional Factors in Compliance," John Linton, Ph.D.

Williamson, Appalachian Power Auditorium, 1st Thursday, 6:30-8:30 P. M.—Feb. (winter break).

March 3, "Suicide Intervention," Martin Kommor, M. D.

New Dean Said 'Outstanding' For Era Of Change

A West Virginia University search committee considered nearly 70 persons before recommending Dr. Richard A. DeVaul of Texas for the post of Dean of the WVU School of Medicine.

This was noted by Dr. John E. Jones, WVU Vice-President for Health Sciences, who called Doctor DeVaul "a man of outstanding credentials and accomplishment, and noteworthy scholarship." Doctor Jones also commented, "We believe he will provide the kind of leadership needed in the era of substantial change which the WVU School of Medicine is entering."

Richard A. DeVaul, M. D.

Doctor DeVaul, whose appointment was announced in December, will take over the WVU post this spring. He currently is Associate Dean for Student and Curriculum Affairs at the University of Texas Medical School at Houston.

Specializing in psychiatry, Doctor DeVaul, 42, received his medical degree from the University of Rochester, and did his psychiatric residency at Johns Hopkins University.

A native of Ames, Iowa, Doctor DeVaul received his bachelor of science degree from Iowa State University, graduating with the highest scholastic honors. During his medical education at Rochester, he was awarded a summer fellowship in cardiology at Stanford University.

Navy Flight Surgeon

After a year of internal medicine residency at University Hospitals in Iowa City, he was a Navy flight surgeon for three years with the Presidential helicopter squadron at Quantico, Virginia, before entering psychiatry residency.

Doctor DeVaul joined the psychiatry faculty at the University of Texas Medical School in Houston in 1974, also serving as Director of Liaison Psychiatry. He also has appointments in the Departments of Medicine and Family Practice, continuing that work after becoming Associate Dean in 1979.

Since 1975 he has been coordinator for the Health Science Center's Pain Clinic, and last year served as Chairman of the Center's Education Task Force.

Doctor DeVaul was Steering Committee Chairman for the University of Texas System Health Professional Schools in 1977-78. He has been an examiner for the American Board of Psychiatry and Neurology, and consultant to a review group of the National Institute of Mental Health.

Research, Clinical Interests

Since 1975 he has authored or co-authored 61 publications, abstracts or other presentations. His research and clinical interests cover a wide range, from chronic pain syndrome and the grieving process to emotional factors in illness and drug dependency.

He is co-author of "Psychiatry's Role in Medical Education," a chapter in the new book, *Psychiatry in Crisis*.

Doctor Jones was Dean of the Medical School from 1974 until his appointment last April as Vice-President. Dr. Robert H. Waldman, Chairman of the Department of Medicine, has been serving as Interim Dean.

The search committee for the new Dean was headed by Dr. Alvin L. Watne at WVU.

AMA Panel To Evaluate New Procedures

The American Medical Association's role in technology assessment has expanded with the appointment of 500 physicians to serve on the new Diagnostic and Therapeutic Technology Assessment (DATTA) project. Selected panelists will answer queries from business, industry, government agencies, and the medical profession on the benefits, risks, and cost-effectiveness of new procedures. With the guidance of the Council on Scientific Affairs, the DATTA panelists will examine medical technologies that are passing from experimental or investigational use to accepted forms of treatment. DATTA will define, where possible, indications for their use.

No fewer than 20 participating physicians will be asked to contribute their expertise in developing responses to each outside inquiry. The panelists' opinions will be tabulated, and a consensus will be issued as to whether a procedure

should be considered as established, investigational, unacceptable, or indeterminate. When a consensus cannot be reached, the council may call for a special study, conference, or report.

In the future, DATTA panelists will be selected by the council from nominations solicited from all segments of the AMA.

HHS Starts Fraud Hot Line For Its Programs

A nationwide toll-free hot line has been established by the U. S. Department of Health and Human Services to receive information about fraud, waste, and abuse in any of the Department's 350 programs, including Medicare and Medicaid. The number is (800) 368-5779. Operators in the Inspector General's office will answer.

As a pilot for the national hot line, HHS set up a local Washington number two years ago. More than 5,900 federal workers and taxpayers have used the local number to report fraud and abuse. About 10 per cent of the complaints resulted in remedial action. In one case, the administrator of a federal program and two contractors went to jail for overcharging Medicare by $567,000.

Physicians' Image Both Positive, Negative

Physicians' public image remains excellent in some areas, according to a public opinion survey conducted by an independent research firm for the American Medical Association. In 1,504 telephone interviews with randomly-selected respondents, the majority said that physicians are accessible in an emergency (81 per cent), explain things well to their patients (55 per cent), take a genuine interest in their patients (68 per cent), are up-to-date on the latest advances in medicine (71 per cent), and genuinely are dedicated to helping people (80 per cent). Some 65 per cent disagreed with a statement that physicians act as if they are better than other people.

The image was tarnished, however, in other areas. People are beginning to lose faith in physicians, said 62 per cent of the respondents. They agreed with statements that physicians are too interested in making money (60 per cent), and disagreed with statements that physicians' fees usually are reasonable (57 per cent disagreed), and that physicians spend enough time with their patients (52 per cent disagreed).

Medical Meetings

Feb. 8-12—Am. College of Emergency Physicians, Surgery/Trauma, Detroit.

Feb. 11-13—Biomedical Topics in Psychiatry (Medical College of VA), Hot Springs, VA.

Feb. 18-20—Regional CME Meeting, Am. College of Physicians, Alexandria, VA.

March 4-6—Am. Medical Student Assoc., Cleevland.

March 5-12, Canadian Am. Medical Dental Assoc., Vail, CO.

March 10-15 — Am. Academy of Orthopedic Surgeons, Anaheim, CA.

March 20-24—Am. College of Cardiology, New Orleans.

April 7-8—WV Chapter, Am. Academy of Pediatrics, Beckley.

April 15-17—WV Chapter, AAFP, Morgantown.

April 16-21—Am. Academy of Pediatrics, Philadelphia.

April 17-21—Am. Urological Assoc., Las Vegas.

April 17-22—Operative Treatment of Fractures & Nonunions (Johns Hopkins University), Hot Springs, VA.

April 18-22—Am. Roentgen Ray Society, Atlanta.

April 22-24—Medical Staff Leadership Seminar (Southern Medical Assoc.), Hilton Head, SC.

April 24-28—Am. Assoc. of Neurological Surgeons, Washington, D. C.

May 4-7—WV Chapter, Am. College of Surgeons, White Sulphur Springs.

May 6-8—Southern Medical Assoc. Regional Postgraduate Conference, Lexington, KY.

May 8-12—Am. College of Obstetricians & Gynecologists, Atlanta.

May 13-14—Topics in Cardiovascular Diseases (Am. Heart Assoc.), Baltimore.

June 19-23—Annual Meeting of AMA House, Chicago.

Aug. 25-27—116th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

Sept. 29-Oct. 2—Am. Society of Internal Medicine, San Francisco.

Oct. 16-21—Am. College of Surgeons, Atlanta.

Nov. 6-9—Scientific Assembly, Southern Medical Assoc., Baltimore.

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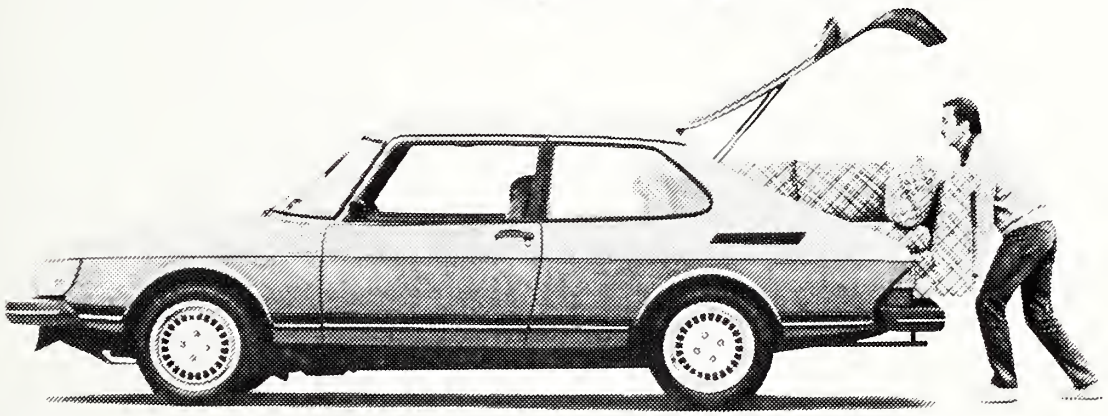

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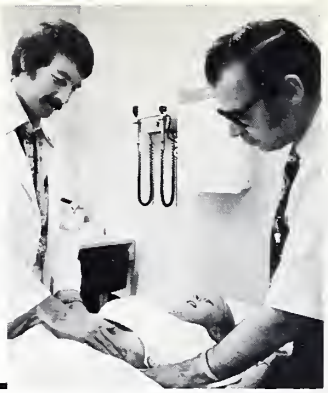

Compiled from material furnished by the Medical Center News Service, Morgantown, W. Va.

Nephrology Chief Receives National Kidney Award

Frederick C. Whittier, Jr., M. D., Professor of Medicine and Chief, Nephrology Section, has been named a recipient of a Distinguished Service Award by the National Kidney Foundation. He received the award for his concern and dedication on behalf of the Foundation and its programs.

A member of the Foundation for 11 years, Doctor Whittier has been active on both the Affiliate and National levels. On the Affiliate level, he served as President of the National Kidney Foundation of Kansas and Western Missouri and as Chairman of its Medical Advisory Board. Nationally, he has served as Chairman of the National Medical Advisory Board, the Sub-committee on Organ Donation and as a member of the Foundation's Executive Committee.

Doctor Whittier also served as Program Chairman of the Foundation's Clinical Dialysis and Transplant Forum for two years beginning in 1978.

A member of the Editorial Board of the Foundation's official journal, the *American Journal of Kidney Diseases*, Doctor Whittier also is a member of numerous other organizations including the American Society of Nephrology, the American Society of Artificial Organs, the American Association of Tissue Banks, the Transplantation Society and the American Society of Transplant Physicians.

Emergency Helipad At WVU Hospital Donated

WVU Hospital will soon have its first paved, lighted and close-in landing pad for helicopters, a gift of James A. LeRosa, Jr., Clarksburg coal operator and businessman.

The landing site, used in bringing critically ill or injured patients to the Medical Center, will be located about 30 yards from the emergency department entrance. A grassy site about 150 yards from the emergency entrance was used previously.

"In the past we had to use an ambulance to transport patients from the landing site to the hospital," said John S. Veach, M. D., Assistant Professor of Surgery and Medical Director of the Emergency Department. "Now we'll have a direct paved walkway, and can bring patients in on wheeled stretchers."

Coordinator for the gift was Alvin L. Watne, M. D., Chairman of Surgery. He said the gift was made in kind, with construction materials and work crews and equipment being provided by LaRosa's firm. Lights donated by Sharpe Electric Co. of Weston will be installed later.

The project involves major earth moving and transporting some 3,000 cubic yards, or 130 truckloads, of fill, paving a 40-foot diameter landing pad with six inches of concrete over six inches of crushed rock, and a 10-foot walkway 30 feet long to the Emergency Department drive. The fill is about eight feet deep at the outer edge, sloping to nearly ground level adjacent to the driveway.

"This will mean a marked improvement in our ability to work with critically ill patients being transported by helicopter," said Dr. Walter H. Moran, Chief of Emergency Services. "The pad will be lighted in accord with FAA regulations, and is in an area cleared of obstructions."

Doctor Wible Heads State Pediatrics Chapter

Kenneth L. Wible, M. D., of the pediatrics faculty is the new Chairman of the West Virginia Chapter of the American Academy of Pediatrics.

Doctor Wible, Associate Professor, took office for a three-year term at the Academy's recent national convention in New York City.

A graduate of Juniata College and the Medical School of Thomas Jefferson University in Philadelphia, Doctor Wible joined the WVU faculty in 1969. He is Director of the Medical Center's pediatric group practice.

"The rehabilitation of head-injured patients is an intensive, sophisticated procedure"

says Jose Amayo, M.D., Harmarville Rehabilitation Center

"From morning 'til night, head-injured patients are involved in rehabilitation," says Dr. Amayo, director of Harmarville's head injury program.

"Our program has four primary elements: cognitive retraining to improve memory, attention span and communication skills; physical restoration services to help patients relearn walking and caring for themselves; a vocational program to prepare patients for employment, further training or education; and programs to help patients deal with routine social and recreational activities.

"We also use a computer and new diagnostic tools, like the evoked potential system. This sophisticated equipment permits us to measure hearing, vision and sensation."

Other special Harmarville programs:

- Pain program to help patients control and live with pain, particularly neck- and back-injured persons.
- Neuro-spinal program for the rehabilitation of quadriplegics and paraplegics.
- Claims Assessment for Rehabilitation Evaluation and Services (CARES) for returning injured workers to maximum level of function and employment.

For more information on Harmarville, its head injury program and admission procedures, call Dr. Amayo, 781-5700.

Harmarville Rehabilitation Center, P.O. Box 11460, Guys Run Road, Pittsburgh, PA 15238

Third-Party News, Views and Program Concerns

Caution In Prospective Payment System Advised By AMA

The American Medical Association has cautioned the Congress to proceed slowly in implementing a system for prospective payment for hospital services.

Joseph F. Boyle, M. D., Chairman of the AMA Board of Trustees, recently told a congressional committee that the AMA supported developing and exploring payment systems for institutions based on "predetermined rates or other payment systems that create incentive for facilities to be more cost-conscious."

He warned, however, that "it would be inappropriate to institute a radical change in the Medicare and Medicaid hospital reimbursement system without assurances that quality care will be maintained."

Doctor Boyle also cautioned against implementing any full-scale prospective payment system "without experimentation and until ongoing projects have been analyzed to determine their effects on costs and quality."

Effects in Human Terms

Testifying before the Health Subcommittee of the House Commerce Committee, the AMA official urged Congress to "consider not only how much these programs are designed to save in terms of dollars but also what effects they will have in human terms and upon the quality of care that will be available to the American people."

In his testimony, Doctor Boyle emphasized that "decisions made in the near future concerning how hospitals and other providers are reimbursed will have long-range implications on access to and the quality of care for years to come."

Hospitals, through their boards, administrators, and medical staffs, are likely to respond to changes in the reimbursement system to try to maintain access and quality care, he said. If hospitals find they are being under-reimbursed, he continued, likely actions will be shifting costs to other payers, deferring such spending as maintenance (often leading to higher long-term costs), and postponing or eliminating necessary modernization and technological improvements, depriving patients of the highest quality of care.

"In extreme cases, hospitals providing essential care could be forced to close," he warned.

Further Demonstrations Urged

Current data are not adequate to confirm that prospective payment is an appropriate nationwide reimbursement system, Doctor Boyle continued. "We strongly urge that further demonstrations go forward before any attempt is made to radically alter the manner in which payment is made for hospital care."

Lacking, he said, is detailed information about what long-term changes would occur in hospitals under a prospective payment system. "What do we do if the 'incentives' change behavior in a way that cuts costs but also forces elimination of needed services and activities?," he asked. "Considerations such as these are best answered through demonstration projects prior to the nationwide implementation of a new Medicare reimbursement system."

"It is important to determine not only whether there are short-term savings that may be generated by a prospective payment system, but also whether the hospitals will continue to be able to provide quality care."

Access Could Be Hindered

The physician pointed out that while prospective payment systems could be tailored to achieve cost savings, "the question of side effects . . . must be considered." He quoted a General Accounting Office report earlier this year warning that "there is a point when a reduction in reimbursement could adversely affect access to and/or quality of care for beneficiaries. Also, if the prospective reimbursement does not apply to all payers, a facility can have an incentive to shift costs to non-covered payers."

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Obituaries

KENNETH E. BLUNDON, M. D.

Dr. Kenneth E. Blundon of Eugene, Oregon, formerly of Charleston, died on November 17, 1982, at his home. He was 64.

Doctor Blundon retired as a urologist in 1978, having been Chief of Urology at Sacred Heart General Hospital in Eugene from 1968 to 1972.

A native of Washington, D. C.; he practiced in Charleston from 1953 until moving to Eugene in 1962.

He was a former member of the Kanawha Medical Society and the West Virginia State Medical Association.

Survivors include the widow; two sons, Kenneth J. Blundon of Springfield, Oregon; Parke E. Blundon of Seattle; a daughter, Elaine Price of Grants Pass, Oregon, and a sister, Mrs. Martha Halluin of Gambrills, Maryland.

* * *

A. C. WOOFTER, M. D.

Dr. A. C. Woofter, Parkersburg internist from 1934 until 1980, died on December 16, 1982, in a Parkersburg hospital. He was 75.

Doctor Woofter was a Past President and honorary member of the Camden-Clark Memorial Hospital staff, and was the first Chairman of the hospital's Department of Internal Medicine. He also was a member of the staff at St. Joseph's Hospital.

A native of Weston, Doctor Woofter was graduated from West Virginia Wesleyan College, and received his M. D. degree in 1933 from the University of Michigan.

He interned at Mercy Hospital in Toledo, Ohio.

He was a Diplomate of the American Board of Internal Medicine, and a Fellow of the American College of Physicians and the American College of Cardiology.

Doctor Woofter was an honorary member and Past President of the Parkersburg Academy of Medicine, and an honorary member of the West Virginia State Medical Association and American Medical Association.

He also was an honorary member and Past President of the West Virginia Heart Association and the Wood County Heart Association, and was a member of the International Society of Internal Medicine.

Doctor Woofter served as a major in the U. S. Public Health Service from 1942 to 1946.

Surviving are two sons, Andrew C. Woofter, Jr., and Joseph C. Woofter, M. D., both of Parkersburg.

* * *

SIEGFRIED WERTHAMMER, M. D.

Dr. Siegfried Werthammer, former Chairman of the Marshall University School of Medicine Pathology Department, died on January 2 in Sarasota, Florida. He was 71.

A native of Vienna, Austria, Doctor Werthammer received his M. D. degree in 1935 from the University of Vienna.

He came to Huntington in 1939 as Director of Pathology at the former Huntington Memorial Hospital.

Doctor Werthammer was Chief Pathologist and Director of Laboratories at St. Mary's Hospital in Huntington from 1942 to 1961, and was Chief of Pathology at Cabell-Huntington Hospital from 1955 to 1979.

He developed the pathology residency training program at Cabell-Huntington for the MU School of Medicine.

Doctor Werthammer was a former member of the Cabell County Medical Society and the West Virginia State Medical Association.

Surviving are the widow; a daughter, Ann Roth of Huntington, and a son, Dr. Joseph

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County Societies

MONONGALIA

The Monongalia County Medical Society met on December 7. The principal speaker was Edward Pastilong, Assistant Athletic Director at West Virginia University. His guests were Darryl Talley, Mark Raugh and Todd Campbell, all WVU varsity football players.

Dr. Richard A. DeVaul, newly appointed Dean of the WVU School of Medicine, was introduced to the Society.

The Society approved a donation of $5,000 to the Morgantown Hospice, Inc. This sum will be matched by the Hazel Ruby Foundation.

A moment of silence was observed in the memory of the late Drs. Clark K. Sleeth and Bernard Zimmermann.—Robert L. Murphy, Executive Secretary.

* * *

TYGART'S VALLEY

The Tygart's Valley Medical Society met on November 18 at the Elkins Motor Lodge in Elkins.

Dr. Harry Shannon of Parkersburg, President of the State Medical Association, addressed the Society on a variety of subjects concerning the Association and the medical profession.

Dr. Carl H. Cather, Jr., of Morgantown was the scientific speaker. His topic was "Ear, Nose and Throat Allergy."—Michael M. Stump, M. D., Secretary.

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Society	President		Secretary		Meetings
Boone	Sriramloo Kesari	Madison	Manuel T. Uy	Madison	2nd Tues.
Brooke	Rogelio L. Velarde	Follansbee	W. T. Booher, Jr.	Wellsburg	
Cabell	Charles E. Turner	Huntington	S. Kenneth Wolfe	Huntington	2nd Thurs.
Central West Virginia	Joseph B. Reed	Buckhannon	Greenbrier Almond	Buckhannon	As Sched.
Eastern Panhandle	John S. Palkot	Martinsburg	Francisco D. Sabado, Jr.	Martinsburg	2nd Wed.
Fayette	Amor H. Ramirez	Montgomery	Serafino S. Maducdoc, Jr.	Montgomery	1st Wed.
Greenbrier Valley	Stephen L. Sebert	Lewisburg	Charles E. Weinstein	Ronceverte	2nd Wed.
Hancock	Reynaldo B. Vista	Weirton	Timothy A. Brown	Weirton	3rd Tues.
Harrison	Gaspar Z. Barcinas	Bridgeport	James E. Bland	Clarksburg	1st Thurs.
Jefferson	Jules F. Langlet	Charles Town	William S. Miller	Ranson	1st Wed.
Kanawha	Donald E. Farmer	Charleston	Robert B. Point	Charleston	2nd Tues.
Logan	Herbert D. Stern	Logan	Tivitmahaisoon Chanchai	Logan	2nd Wed.
Marion	P. Kent Thrush	Fairmont	Mack I. McClain	Fairmont	Last Tues.
Marshall	Carlos C. Jimenez	Glen Dale	Jose J. Ventosa	Glen Dale	1st Tues.
Mason	Mel P. Simon	Point Pleasant	Richard L. Slack	Point Pleasant	4th Tues.
McDowell	Haresh Khatri	Welch	John S. Cook	Welch	2nd Wed.
Mercer	Mario Cardenas	Princeton	David F. Bell, Jr.	Bluefield	3rd Mon.
Mingo	Edward B. Headley	Delbarton	Nikhanth Purohit	Williamson	2nd Wed.
Monongalia	N. LeRoy Lapp	Morgantown	Robert Bettinger	Morgantown	1st Tues.
Ohio	Thomas L. Thomas	Wheeling	James C. Durig	Wheeling	4th Tues.
Parkersburg Academy	Billie M. Atkinson	Parkersburg	John E. Beane	North Parkersburg	1st Thurs.
Potomac Valley	Suratkal V. Shenoy	Keyser	Larry C. Rogers	Keyser	2nd Wed.
Preston	Gary W. Lawrence	Kingwood	C. Y. Moser	Kingwood	4th Thurs.
Raleigh	Jose L. Oyco	Beckley	William C. Covey, Sr.	Beckley	3rd Thurs.
Summers	Jack D. Woodrum	Hinton	Chandra P. Sharma	Hinton	3rd Mon.
Tygart's Valley	Karl Myers, Jr.	Philippi	Halberto G. Cruz	Philippi	3rd Thurs.
Western	Herminio L. Gamponia	Spencer	Ali H. Morad	Ripley	Bi-Monthly
Wetzel	Donald A. Blum	New Martinsville	K. M. Chengappa	New Martinsville	Monthly
Wyoming	Frank J. Zsoldos	Mullens	George F. Fordham	Mullens	Quarterly

The West Virginia Medical Journal

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Acquired Factor VIII Inhibitor* (A Case Report)

SUSAN IRBY, M. D.
Pittsburgh, Pennsylvania

JOHN S. ROGERS II, M. D.
Associate Professor of Medicine, Section of Hematology/Oncology, Department of Medicine, West Virginia University Medical Center, Morgantown

DOUGLAS C. WOLF, M. D.
Cleveland, Ohio

An elderly woman presenting with gross hematuria and later gastrointestinal bleeding was found to have an acquired inhibitor to clotting Factor VIII. Transfusions with large amounts of Factor VIII concentrate transiently corrected the prolonged partial thromboplastin time (PTT) and the depressed Factor VIII clotting level.

Additional laboratory abnormalities included mild prolongations of both prothrombin time (PT) and thrombin time (TT) which were not corrected in vitro by the addition of equal volumes of normal plasma or in vivo by Factor VIII infusion.

A diagnostic approach to a patient with a suspected clotting inhibitor is discussed. The present case is compared to previous reported cases of acquired Factor VIII clotting inhibitors.

Acquired Factor VIII inhibitors most commonly occur in hemophilia patients receiving Factor VIII infusions but have been described in non-hemophiliacs.[1,2,3,4] We report a patient with an acquired Factor VIII clotting inhibitor. The present case is compared to previous reported cases. The need for appropriate diagnosis and treatment is discussed.

*This paper was written while Doctors Irby and Wolf were residents in medicine at West Virginia University Medical Center, Morgantown.

Case Presentation

A 72-year-old black female was admitted for evaluation of gross hematuria of three weeks' duration. The patient denied previous episodes of hemorrhage, and had undergone both an appendectomy and full-mouth dental extraction in the past without significant bleeding. She had been taking aspirin for two years for degenerative arthritic pain, and more recently cimetidine (Tagamet) for epigastric discomfort. Her medical history further revealed a poorly substantiated diagnosis of multiple myeloma made one year previously. She had been treated with lumbar radiation and daily oral dexamethasone (Decadron).

During her recent hospital course, cystoscopy and retrograde pyelography revealed bleeding from both ureteral openings, and hydronephrosis of the right kidney. Table 1 shows the initial coagulation studies. The partial thromboplastin time (PTT) was markedly elevated, and the prothrombin time (PT) and thrombin time (TT) were mildly prolonged. The platelet count and Ivy bleeding time were normal. The plasma fibrinogen and fibrin split products (FSP) were both increased.

Further laboratory evaluation revealed the presence of a Factor VIII clotting inhibitor of moderate titer. The PTT was repeated on serial dilutions of the patient's plasma with normal plasma. One would expect a clotting factor de-

ficiency to be corrected by an equal volume of normal plasma, that is, a 1:1 dilution. In our case, complete correction of the prolonged PTT did not occur until the 1:8 dilution. Incubation of the mixture at 37° C for one hour enhanced the inhibition, i.e., the PTT of the mixture prolonged further with time. The patient's clotting Factor VIII level (F VIII-C) was decreased to 0.14 units/ml (normal range 0.56-1.55 units/ml). Levels of Factors II, V, IX and X were all normal. Quantitation of the Factor VIII inhibitor activity by the method described by Kasper[5] revealed a moderate titer of 18 Bethesda units.

Reason Not Clear

While the prolonged PTT is explained by the Factor VIII inhibitor, the reason for the abnormalities in the PT and TT is not clear. The mixing of equal volumes of patient and control plasma (1:1 dilution) produced incomplete correction of the PT and TT. Transfusions of large amounts of Factor VIII concentrates corrected the prolonged PTT and the depressed Factor VIII level. Table 2 shows normalization of the Factor VIII level with marked shortening of the PTT one hour post-infusion. The mild abnormalities of the PT and TT were not affected.

The evaluation of our patient for underlying disease was inconclusive. An abnormal pap smear was suggestive of malignancy. Following infusion of a large dose of Factor VIII concentrate, cervical biopsy plus dilatation and curettage were performed without significant bleeding.

TABLE 1
Initial Lab Studies

	Patient	*Normal*
PTT	72.0 sec.	31.4 sec.
PT	13.5 sec.	10.6 sec.
TT	43.4 sec.	23.7 sec.
Platelets	375,000/cu mm	140-440,000/cu mm
Fibrinogen	530 mg/dl	200-400 mg/dl
FSP	>40 μg/ml	<10 μg/ml
Ivy BT	4 min.	1-6 min.

TABLE 2
Effects of Infusion of 10,000 Units of Factor VIII Concentrate

	Normal	*Pre*	*Post*
F VIII	1.00 ± .21 u/ml	0.14 u/ml	1.09 u/ml
PTT	33.4 sec.	62.8 sec.	41.4 sec.
PT	11.1 sec.	13.8 sec.	13.2 sec.
TT	23.4 sec.	34.4 sec.	41.2 sec.

The cervical biopsy showed epithelial dysplasia. The endocervical and endometrial scrapings revealed atypical cells suggestive of malignancy. The presence of multiple myeloma was not confirmed by bone marrow biopsy or by serum and urinary electrophoresis.

While hospitalized, the patient developed an upper gastrointestinal bleed. Endoscopy examination revealed duodenitis. The patient was continued on the Factor VIII concentrate infusions on a daily basis with control of major bleeding symptoms. Two weeks prior to discharge she was begun on Prednisone 20 mg. every six hours. The requirement for Factor VIII infusions gradually decreased, and she was discharged on prednisone.

The patient was seen two weeks later as an out-patient. Both the hematuria and gastrointestinal bleeding had resolved. At that time, the inhibitor titer had decreased to five Bethesda units. The PTT had decreased to 38.8 sec., and the Factor VIII level was 0.46 u/ml. One month later, the patient was admitted to another hospital where she died secondary to gastrointestinal bleeding. An autopsy was denied.

Discussion

The *in vitro* and *in vivo* studies in our patient are consistent with an acquired F VIII inhibitor of moderate titer. The reason for the mild prolongation of the PT and TT in our patient is uncertain. The incomplete correction of the TT *in vitro* by equal volumes of control plasma and *in vivo* by Factor VIII concentrate infusion suggests a second site of inhibition, perhaps due to the increased fibrin split products. Fibrin split products are known to have an antithrombin effect. The presence of elevated FSPs with a normal platelet count and increased plasma fibrinogen raises the possibility of compensated disseminated intravascular coagulation (DIC) or primary fibrinolysis.

Acquired Factor VIII inhibitors occur most commonly in hemophiliacs, but have been associated with a variety of disease states. In a 1975 review article, Shapiro[4] cited patients with long-standing asthma, pemphigus, psoriasis, and non-specific dermatitis who developed inhibitors to Factor VIII. Patients with connective tissue disease such as systemic lupus erathematosis, rheumatoid arthritis and temporal arteritis occasionally have inhibitors to Factor VIII. Anticoagulants also have been found in patients in the postpartum period,[2] in patients with dysproteinemias,[6] and have been associated with

reactions to penicillin, nitrofurazone, phenylbutazone and sulfa.[3]

Non-hemophiliac children have been reported to develop Factor VIII inhibitors after viral infections.[1] Others have noted a connection between inhibitors and occult malignancy, and in elderly patients who are otherwise healthy.[2,3] Factor VIII inhibitors have been described in patients with cancer, including Hodgkin's disease, prostate cancer, myelofibrosis and cancer of the cervix.[7]

The Factor VIII inhibitor has been characterized as an auto-antibody mainly of the IgG class.[2] Subtyping reveals the majority to be of the IgG_4 subclass. The light chain is frequently restricted, with Kappa chains occurring most commonly in hemophiliacs with inhibitors. The reaction with Factor VIII follows first order kinetics and is progressive. The reaction requires several hours and can be dissociated. The progressive nature of the reaction was apparent in the correction studies in our patient. The inhibitor may disappear after several weeks or may persist for years.

Why the Anticoagulant?

The cause of the circulating Factor VIII anticoagulant in our patient is unclear. The diagnosis of multiple myeloma was not confirmed. In regard to medication, the patient had been taking dexamethasone and cimetidine prior to the onset of hematuria. Neither drug is known to be associated with Factor VIII inhibitor formation. The possibility exists that the patient had endometrial or cervical carcinoma.

While the incidence of acquired Factor VIII inhibitor is low, it may be the cause of significant morbidity and mortality. Suggested treatment includes infusion of large doses of Factor concentrate. If the inhibitor is of low titer, as in the present case, such an approach may control bleeding. Plasma exchange transfusions may be employed in an attempt to decrease the amount of circulating inhibitor; however, the effects are transient, as the majority of the IgG antibody is extravascular.[8]

Immunosuppression with cyclophosphamide or prednisone requires several weeks to months to affect the inhibitor level, and is frequently ineffective. Prothrombin complex concentrates contain Factors II, VII, IX and X. Factors IX and X may appear in the activated form. Clinical studies involving hemophilia patients with Factor VIII inhibitors suggest that prothrombin complex concentrates may partially bypass the need for Factor VIII in thrombin formation and improve hemostasis.[8] Newer preparations specifically designed to contain activated vitamin K-dependent clotting factors are now commercially available.[9]

Acquired clotting Factor VIII inhibitors can be life-threatening, but with proper diagnosis and hematological support, bleeding can often be stabilized. Control of an associated underlying disease may lead to the disappearance of the inhibitor. On occasion, spontaneous remissions or responses to immunosuppression occurs. Therefore, it is important to be able to recognize the nature of the bleeding disorder and, if an inhibitor is found, to search for its cause, while appropriate hematological support is given.

Acknowledgements

The authors wish to thank Frances S. Jencks for technical assistance and Annorah L. Cale for secretarial assistance.

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Early Attenuation Of Toxic Shock Syndrome With Intravenous Nafcillin Sodium

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A 22-year-old woman presented with an acute febrile illness suggestive of Toxic Shock syndrome. Early treatment with intravenous nafcillin sodium and aggressive fluid replacement attenuated the majority of signs and symptoms. Subsequent recovery of coagulase-positive staphylococcus aureus from vaginal cultures confirmed the diagnosis. It is suggested that more liberal criteria be used to define Toxic Shock syndrome to allow earlier recognition and treatment and thus prevent morbidity.

TOXIC SHOCK syndrome (TSS) is an acute illness characterized by the abrupt onset of fever, headache, gastrointestinal symptoms and a characteristic erythematous rash which invariably progresses to desquamation one to two weeks later.[1] As the name implies, profound hypotension with consequent oliguria are prominent features, often requiring intensive intravenous therapy and occasionally dialysis.[7,8]

TSS is now recognized as a unique disease occurring almost exclusively in women who are using tampons.[2-4] Epidemiologic studies suggest that the causative agent is a toxinogenic strain of coagulase-positive staphylococcus aureus (CPS) which has been recovered from the vaginas of the majority of patients.[5,6]

We report the following case of TSS in which the early administration of intravenous nafcillin sodium (Nafcil) markedly reduced the severity of the illness. The accepted criteria for establishing the diagnosis of TSS were not initially met by our patient, thus necessitating a high index of suspicion in order to initiate appropriate therapy.

Case Report

A 22-year-old, white, female college student reported to the emergency room at Jefferson Memorial Hospital on March 11, 1982, following a syncopal episode. The patient had been experiencing headache, fever, nausea and vomiting, and diarrhea for 12 hours. She had seen the school nurse on two occasions and was given acetaminophen (Tylenol) for the fever and kaolin-pectin (Kaopectate) for the diarrhea. The patient had an episode of orthostatic syncope in her dormitory and was brought to the emergency room.

On further questioning the patient noted that she had been on her menstrual period for the past week and that she was using tampons (Playtex Super-absorbent). She also recalled having had an infected hair follicle on her right thigh prior to the onset of her period. The patient denied any prior history of menstrual-related illness, and was on no medications other than those mentioned.

On physical examination the patient appeared ill but was alert and well-oriented. Temperature was 100^6 degrees Farenheit; pulse, 88; blood pressure, 102/70 supine and 98/70 sitting, and respiratory rate, 20. The skin was warm and dry. There was a diffuse erythroderma of the face and chest suggestive of a mild sunburn. The conjunctiva were inflamed but without exudate, and the pharynx was normal-appearing. There was no adenopathy. The lungs were clear to auscultation and the heart sounds were normal. The abdomen was soft with active bowel sounds and no tenderness or guarding.

A pelvic examination was performed, the tampon removed and vaginal cultures obtained. There was a scant white discharge with no bleeding from the cervical os. The uterus and adnexa were normal. A thorough search for the reported infected hair follicle was negative.

Laboratory studies obtained on admission included urinalysis with s.g. 1.020, pH 5.0, 3+ glucose, 2+ acetone and six to eight white blood cells per high-power field. Hemoglobin was 13.6 g/dl with hematocrit of 40.3 per cent. The white blood cell count was 10,400 with 92 per cent neutrophils, five per cent bands and three per cent lymphocytes. Blood urea nitrogen was 14 mg/dl, serum glucose, 120 mg/dl, and amylase, 45 mg/dl. Serum electrolytes were as follows: sodium, 143; potassium, 3.8; chloride, 100, and bicarbonate, 25(mEq/L). Gram stain of the vaginal fluid revealed mixed flora and few polymorphonuclear cells. Cultures of blood, urine and pharynx were taken during the initial examination.

Hospital Course

The presumptive diagnosis of Toxic Shock syndrome was made and the patient admitted to the intensive care unit. She was treated with nafcillin sodium one gram intravenously every four hours, as well as rapid infusion of five-per cent dextrose in normal saline. During the first eight hours, total urine output was only 325 ml.

The patient became afebrile on the second hospital day with urine output returning to normal. At this time she had developed edema of the face, hands and feet, and was complaining of paresthesias of the hands, but was otherwise markedly improved.

Cultures of blood and urine were negative on the third hospital day, and the pharyngeal culture was negative for group A streptococcus. Vaginal cultures obtained on admission yielded a heavy growth of coagulase-positive staphylococcus aureus. The patient was placed on oral cloxacillin (Tegopen) and was discharged on the morning of the fourth hospital day.

Two weeks following the onset of illness the patient developed large-flake desquamation of fingers, palms and soles. The paresthesias had completely resolved. Subsequent vaginal cultures were negative for CPS on two occasions. The patient has completely discontinued the use of tampons, and has had two normal menstrual periods as of this writing.

TABLE

Toxic-Shock Syndrome Case Definition

1. Fever (temperature >38.9 C (102 F)).
2. Rash (diffuse macular erythroderma).
3. Desquamation, 1-2 weeks after onset, particularly palms and soles.
4. Hypotension (systolic blood pressure <90 mm Hg.) or orthostatic syncope.
5. Involvement of three or more of the following organ systems:
   - A. Gastrointestinal (vomiting or diarrhea).
   - B. Muscular (severe myalgia).
   - C. Mucous membrane (vaginal, oral, or conjunctival hypermia).
   - D. Renal (BUN or Cr > 2 x ULN or > 5 white blood cells per high-power field).
   - E. Hepatic (total bilirubin, SGOT, or SGPT > 2 x ULN).
   - F. Hematologic (platelets < 100,000/mm^3).
   - G. CNS (disorientation or alterations of consciousness).
6. Negative results on the following tests, if obtained:
   - A. Blood, throat, urine, or cerebrospinal fluid cultures.
   - B. Serologic tests for Rocky Mountain Spotted Fever, leptospirosis, or measles.

Discussion

Todd first described TSS as a new entity in 1978.[1] TSS was distinguished from Kawasaki disease by its predilection for older children (8-17y/o) and its unique association with phage-group-I CPS. A specific exotoxin produced by the CPS was felt to be responsible for the multi-system involvement as well as the characteristic desquamating erythroderma.

The Center for Disease Control (CDC) issued a bulletin in 1980 announcing the high prevalence of TSS in menstruating women.[2] CPS were cultured from 73 per cent of cases, and the overall case-fatality ratio was then as high as 15 per cent. Subsequent CDC reports issued warnings that the use of specific brands of tampons put these women at high risk for TSS.[3,4] Later reports, however, proved no brand-specific association.[3,6] The table lists the criteria for case definition of TSS as issued by the CDC.[3]

The present case is of interest for several reasons. First, our patient presented in a more subtle manner than the majority of cases reported in the early series.[5-8] This may be due in part to the fact that we saw the patient within the first 12 hours from the time of onset, whereas most cases reported were seen on the second day.[10] A high index of suspicion led us to make an earlier diagnosis than would be allowed by the currently accepted criteria. Recently, other investigators have suggested that more liberal criteria might aid in the earlier recognition of TSS.[11]

A second unusual feature of the present case was the development of paresthesias of the hands. This has been previously reported.[10] Other reported sequelae to TSS have included renal failure, laryngeal paralysis, adult respiratory distress syndrome, alopecia, and recurrent episodes of TSS during subsequent menstrual periods.[5]

Pathway of Infection

A third point of interest in our patient was the reported infected hair follicle. Although we were unable to document this on physical examination, it does bear out one theory as to the pathway of infection in these patients: supposed innoculation of the vagina with CPS through the insertion of contaminated tampons.[9] Our patient must certainly have done this, as the temporal relationship between the discovery

of the furuncle and the onset of TSS was less than one week.

We began treatment initially with intravenous nafcillin sodium specifically directed at the suspected CPS colonization of the vagina. This course of therapy has been proved to be efficacious by other investigators.[3,5,9] The use of beta-lactamase-resistant antibiotics has reduced the relapse rate in most series. As of this writing, our patient has had two normal menstrual periods without relapse.

Conclusion

We have presented a case of Toxic Shock syndrome with some unusual features, the most notable of which was a lack of severity usually associated with this disease. Our patient was treated specifically with intravenous nafcillin sodium, and had a rapid recovery with no permanent sequelae and no relapses of TSS. We suggest that more liberal criteria be used to define TSS in order to allow earlier treatment with specific antibiotic therapy as well as general supportive measures.

Acknowledgements

We would like to thank Loretta E. Haddy, State Epidemiologist with the West Virginia Department of Health, for her assistance in this case report.

Editor's Note: Here are the generic drugs and trade names (in parentheses) to which reference is made in this manuscript: nafcillin sodium (Nafcil), acetaminophen (Tylenol), kalin-pectin (Kaopectate), and cloxacillin (Tegopen).

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ECHOCARDIOGRAPHY

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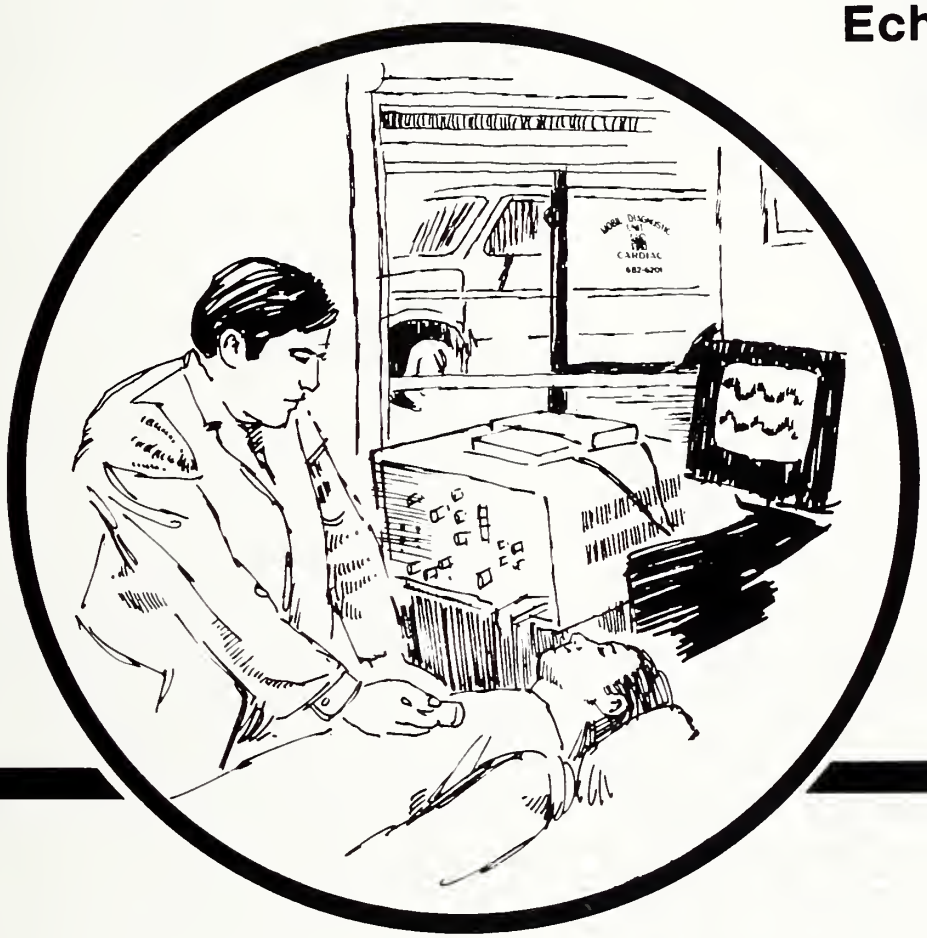

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A message from . . .

The President

THIS ONE'S FOR YOU . . .

TIMES are tough in West Virginia. The economic crunch has hit. Our unemployment rate is one of the highest, if not the highest, in the nation, and for a great many of these people, their health benefits are running out. The Department of Welfare is attempting to avoid cuts in medical services, but because of other budget cuts is forced to cut almost all social services contracts. The state Public Employees' Insurance Board (responsible for the health benefits payments of some 94,000 public employees) is projecting a deficit of at least $9 million for fiscal year 1983. The Chief Justice of the Supreme Court has issued an appeal for contributions to a food fund to provide food for needy families. The doleful litany of economic hardships continues.

In my travels throughout the state on your behalf, one of the bright spots in this bleak economic landscape I have found is the encouraging number of our physicians who are contributing their time and talents for little or no remuneration. Many are not sending in Medicaid claims. Others are writing off bills for families in severe economic circumstances, or arranging long-term deferred payments. The doctors volunteering for the Handicapped Children's Services program devote their time far in excess of what they would usually expect to receive. These doctors generally do not get any kind of credit or publicity for their actions. This is a form of "good news," and good news does not sell newspapers or get media attention to the extent that bad news does.

Obviously, not all our members can participate in these actions. In areas where practices are comprised of 40-50 per cent of publically-assisted patients, the income from the state may be the difference between keeping the office or clinic open or shutting it down. Certain areas of our state, unfortunately, have more than their share of the medically-indigent population, and doctors in these areas must utilize all revenue sources. I understand this and commend them for their provision of quality medical care with less than optimum resources.

The generosity of our physicians who are sharing the burden of the economic times with their patients is praiseworthy and appreciated. I would urge you to consider, where appropriate, extending and enlarging this generosity, to insure that those who need quality medical care are not hampered in their efforts to achieve it by the fear of inability to pay. I am not aware of any instance where someone who truly needed care was turned away purely because of an inability to pay for it.

So, I personally ask all of you who have not considered this before to give it your immediate attention. And, for the many of you who have been doing this all along: who have been providing quality medical care at a considerable sacrifice of your time and talents: and who have been largely unsung and unpublicized for all this time, my hat is off to you. As the song says, friends, "This One's For You!"

Harry Shannon M.D.

Harry Shannon, M. D., *President*
West Virginia State Medical Association

The West Virginia Medical Journal

Editorials

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author shall be held entirely responsible. Editorials printed in The Journal do not necessarily reflect the official position of the West Virginia State Medical Association.

Conservative estimates place costs of "defensive medicine" at 30 per cent of total medical care costs. Figures such as these are generally marshaled in any effort to lay at the feet of physicians blame for the towering costs of medical care.

RIGOROUS STANDARDS

Since these costs are generated for purposes of defending the physician from allegations of negligence, one is to infer that they are not only unnecessary but even self-serving and selfishly motivated.

It is an attractive argument and one most often enthusiastically received by an audience primed to damn Medicine and physicians at any opportunity. The logic of the argument, however, escapes detection in any serious examination of the proposition.

If one can accept the assumption that some serious jeopardy faces the physician if he is, in fact, found negligent, what then is it in the field of negligence against which he seeks to defend himself via extraordinary diagnostic studies? The answer to this is, of course, that the physician seeks to defend himself against charges of negligence for failing to uncover a rare disease or one totally unrelated to the complaints and symptoms of concern bringing that patient to the physician in the first place.

The standard against which a physician's performance is measured has been escalated to rigorous levels. If a patient visits a physician, complains of and is treated for an upper respiratory infection and turns up a month or two later with carcinoma of the pancreas, the physician could be found negligent for failing to diagnose the occult condition. The visit of any new patient or any old patient not recently seen thus becomes an occasion demanding a sophisticated, time-consuming and very expensive workup.

With the physician subject to such a standard it is remarkable that rises in medical care costs have been so moderate. The control of these costs so far demonstrated can only have been accomplished at the expense of major risks taken by physicians willing to dare the avarice and cupidity of predatory plaintiff's attorneys.

The impossible standard is not one set by Medicine. It is set, of course, by the courts, aided, abetted, promoted and encouraged by some members of the legal profession whose zeal to protect patients is exceeded only by that they display for fattening their own wallets.

Who, then, is responsible for the costs attributed to defensive medicine — the physician for using common sense and decent judgment in defending himself, or plaintiff's attorneys and the courts for promoting and tolerating the imposition of impossible standards?

The West Virginia State Medical Association has prepared for introduction into this session of the Legislature bills to effect changes in tort law which will have the effect of moderating the risks involved in violating the most onerous provisions of the impossible medical negligence standard presently being applied. Those citizens and particularly those legislators with any serious intent to help hold down further rises in medical care costs should examine these bills closely.

The idea of prospective reimbursement has been getting considerable attention — and has been tried in several states — as a possible national dollar-saving solution to the upward trend in health care costs.

SAVE NOW, PAY LATER?

Such systems function in a generally similar fashion. A rate-setting body determines payments in advance for services, cases or diagnoses. Individual hospital patients, or their insurance carriers, must pay those rates when admitted to a hospital, regardless of length of stay.

Hospitals may either profit, if patients are discharged early; break even; or lose, if patients are hospitalized longer than the predetermined length of stay.

David A. Smith, M. D., Medical Editor for *Pennsylvania Medicine*, has expressed some

thoughts about prospective reimbursement as 1982 Medicare amendments have mandated the development of such a program for 1983 congressional consideration. Here are his views:

"If a prospective reimbursement program becomes a national reality within the next few years, as it appears that it may, there are three areas in which physicians should be prepared to respond. The first is quality of care. What will be the effect? Will hospital costs be considered before quality, and will cost overrule quality?

"The second is malpractice. Will the standards that are developed for reimbursement be used as evidence in malpractice cases? That is, if a physician releases a patient from the hospital sooner than the average length of stay determined for the standard, will vulnerability be increased?

"Third is the continued development of medicine and medical care. Scientific research will be wasted if the new technologies cannot be applied to patient care. Will better equipment and new services become an unaffordable luxury as prospective reimbursement programs reduce payment percentages in the name of cost containment?

"While prospective reimbursement programs have been touted as the only regulatory mechanism showing progress in curbing the rise in health costs, we must not be mesmerized by the dollar savings in the short term. The long-term costs of these programs in terms of enforced acceptance through cost constraints of less than top quality medical care may be far more expensive than our present, less-than-perfect, system.

"Like the television commercial suggests, 'you can pay me now or pay me later.' It implies that skimping now probably will be a lot more expensive in the long run."

The dramatic medical breakthrough in the Barney Clark case — the successful implantation of a permanent artificial heart in a human patient — illustrates once again the amazing strides being made in medical technology.

ON THE ARTIFICIAL HEART

It also gives pause to thoughtful individuals as they consider the long-range implications of this latest example of progress.

Obviously, many years and much more testing will be required before the artificial heart will be available to aid patients on a widespread basis. Eventually, however, its widespread use seems likely.

The unanswered question is cost. Consider this example: In 1972, Congress approved coverage of renal dialysis for Medicare patients, with an estimated cost of about $250 million per year. For 1983, the estimated cost is more than $2 billion. The cost of the artificial heart device alone is more than $16,000. That figure is exclusive of all other costs. Any estimate of the cost of widespread use of this technique would be mere speculation.

The artificial heart illustrates the capability of today's technology and of its brilliant scientists. Similar dramatic progress is inevitable in other fields.

Can society afford to make this wonderful new technology available to every patient who needs it? If not, who shall decide which patients do receive it? Medicine and society must make some agonizing decisions in the future. — *American Medical News, December 17, 1982.*

MORE ON THE ARTIFICIAL HEART

The above editorial addresses the problem of cost of implantation of the artificial heart. Cost is not the only "unanswered question." The heart is the only organ in the body that has one function: it is a simple pump. Between one-third and one-half of Americans succumb to heart attack or heart failure as a result of damage to this pump. It seems likely that the technical problems that occurred with Barney Clark's artificial heart will soon be corrected and perfected. In the foreseeable future a model which can function indefinitely may be available.

We can speculate that in time implantation of an artificial heart could prolong the lives of countless thousands, perhaps millions, of Americans. Approximately 15 to 20 per cent of people over the age of 70 now suffer from chronic dementia requiring custodial or home care by other individuals. This could double in the next 10 to 20 years. It is not likely that artificial livers, lungs, and kidneys — much less brains — are on the horizon.

Adding to life expectancy with artificial hearts, without prospect of any means of reversing the natural aging process, could greatly increase the number of demented people. Hearts that keep on beating and pumping blood to organs that continue to wear normally may create new problems for society.

This is not just a problem of medical cost, but one of deeper social and ethical significance.

GENERAL NEWS

AMA President To Speak At Annual Meeting

Dr. Frank J. Jirka, Jr., M. D., who will be installed as President of the American Medical Association in Chicago in June, will speak during the State Medical Association's 116th Annual Meeting in August. Doctor Jirka, a urologist practicing in Barrington and Berwyn, Illinois, will address the first session of the House of Delegates Thursday afternoon, August 25.

The convention will be held August 25-27 at the Greenbrier in White Sulphur Springs. It will open with a pre-convention session of the Association's Council and the first House session on Thursday morning and afternoon; and end with the second and final House session and reception for new Association officers on Saturday afternoon and evening.

Long active in organized medicine, Doctor Jirka was first elected to the AMA Board of Trustees in 1974. He served as its Secretary in 1976-77 and as its Vice Chairman from 1977 to 1979. Doctor Jirka has served the Illinois State Medical Society as its President, Chairman of the Board of Trustees, and as a Delegate to the AMA House of Delegates. Currently, he is a Councilor of the Chicago Medical Society.

M. D. from University of Illinois

Born in Illinois, Doctor Jirka attended Knox College in Galesburg, Illinois, before entering the University of Illinois College of Medicine where he received his M. D. degree in 1950. He served his internship and residency at Cook County Hospital, Chicago, from 1950-54. Doctor Jirka is a Diplomate of the American Board of Urology, and a Fellow of the American College of Surgeons and the International College of Surgeons.

Motivated by severe injuries sustained as a Navy frogman during World War II, resulting in the amputation of both his legs below the knee, Doctor Jirka has devoted a great deal of his time toward rehabilitation programs. He has served on the President's and the Governor's Committees on Employment of the Handicapped, and has been a Board member of the Illinois Association of Crippled Children as well as the Illinois Rehabilitation Association.

Doctor Jirka is a Clinical Associate Professor in Urology at Loyola University Stritch School of Medicine, a Consultant in Urology at Hines Veterans Administration Hospital, and formerly was an Associate Professor in Urology at Cook County Graduate School of Medicine.

Doctor Jirka and his wife, Pat, have three daughters, Lynn J. Sutherland, Mary Pat, and Ella Kay.

Scientific Sessions

The initial general scientific session, as announced earlier, will be a symposium on sexually transmitted diseases. It will be held at 9:45 A. M. on Friday, August 26, preceded by the traditional opening exercises. A keynote speaker for the latter program will be announced later by the Annual Meeting Program Committee.

David Z. Morgan, M. D., of Morgantown, the Program Committee Chairman, said the first

Frank J. Jirka, Jr., M. D.

scientific session Friday morning will include papers on these individual topics:

Syphilis and gonococcal infections; non-luetic, non-gonococcal venereal diseases; transmissible diseases of the gay patient, and sexual mores in the 1980s.

The second general scientific session will be held Saturday morning, August 27 and, also as announced previously, will be a symposium on cardiovascular diseases. The Saturday morning topics will include new developments in the management of cardiac arrhythmias: an update relative to cardiovascular surgery, and the management of congestive heart failure.

Specialty Groups

In addition to the general sessions, the Annual Meeting agenda will include breakfast, luncheon and other programs arranged by specialty societies and sections, many of which also will provide scientific discussions.

The specialty group meetings will be held in large measure on Friday, with a few to be set for Saturday morning, preceding the second general session, and at noon.

At the final House session on Saturday afternoon, Carl R. Adkins, M. D., of Oak Hill will be installed as the Association's 1983-84 President to succeed Harry Shannon, M. D., of Parkersburg.

Continuing a practice of many years, the Auxiliary to the State Medical Association, with Mrs. Richard S. Kerr of Morgantown the current President, will hold its meeting in conjunction with that of the Association.

Serving with Doctor Morgan on the 1983 Program Committee are Doctor Adkins; Jean P. Cavender, M. D., Charleston; Michael J. Lewis, M. D., St. Marys; Kenneth Scher, M. D., Huntington, and Roland J. Weisser, Jr., M. D., Morgantown.

Additional information concerning speakers and other convention details will be provided in upcoming issues of *The Journal.*

Infection Control, Tumors CME Program Topics

An Infection Control Workshop and Symposium on Tumors will be among continuing medical education programs offered by West Virginia University School of Medicine and other sponsors in March.

The Infection Control Workshop will be held Friday afternoon and Saturday morning, March 25-26, at Lakeview Inn in Morgantown. The Program Director will be R. Brooks Gainer II, M. D., WVU Clinical Associate Professor, Section of Infectious Diseases, and Chairman, Infection Control Committee, Monongalia General Hospital, Morgantown. The WVU Department of Medicine, Section of Infectious Diseases, and the hospital are the sponsors.

The Symposium on Tumors, designed to provide the practicing orthopedic surgeon with a

Some 250 physicians and others attended the 16th Mid-Winter Clinical Conference in Charleston January 21-23 under the sponsorship of the State Medical Association and the West Virginia University and Marshall University Schools of Medicine. In the left photo, conference material is examined by Drs. Joseph T. Skaggs (left) of Charleston, Chairman of the Program Committee, and Harry Shannon, Parkersburg, Association President. On the right are two of the Friday afternoon, January 21, speakers, Drs. Jack M. Bernstein (left), Huntington, and Larry I. Lutwick, Brooklyn, New York.

perspective regarding the treatment of bone tumors within the community hospital setting, is scheduled for March 28-29 at the Greenbrier in White Sulphur Springs.

Material, to be presented entirely by the case method, will cover metastatic lesions, benign tumors of the bone, malignant tumors, and segmental resection.

Tumor Symposium Faculty

Members of the faculty will be Drs. William Enneking, Distinguished Service Professor of Orthopedic Surgery, University of Florida; Henry J. Mankin, Edith M. Ashley Professor of Orthopedic Surgery, Harvard Medical School, and Chief of Orthopedics, Massachusetts General Hospital, Boston; John Murray, Clinical Associate Professor of Orthopedics, Baylor College of Medicine and University of Texas at Houston, and Chief of Orthopedics, M. D. Anderson Hospital and Tumor Institute, Houston;

Douglas Pritchard, Head of Section, Orthopedic Oncology, Mayo Clinic, and Associate Professor, Mayo Medical School; Eric L. Radin, WVU Professor and Chairman, Orthopedic Surgery; Allan Schiller, Associate Professor, Pathology, Harvard Medical School and Massachusetts General Hospital; and Jamshid Tehranzadeh, WVU Assistant Professor of Radiology and Chief, Bone Radiology Section.

Sponsors are the WVU Department of Orthopedic Surgery and Office of Continuing Medical Education.

Infection Workshop Speakers

Speakers and topics for the infection workshop will be: "Making Infection Control Applicable to the Patient"—Sue Crow, R.N., M.S.N., Nurse Epidemiologist, Louisiana State University; "Herpes Simplex—Impact on Patient and Staff"—Robert Belshe, M. D., MU Associate Professor of Medicine and Microbiology, Section of Infectious Diseases; "Hepatitis B Vaccine—AIDS"—C. Glen Mayhall, M. D., Associate Professor of Medicine, Medical College of Virginia; "Infections of Surgical Patients and Prevention of Surgical Infections"—Ronald Nichols, M. D., Professor of Microbiology and Immunology, Department of Surgery, Tulane University;

"Influenza and Influenza Vaccines"—Robert Waldman, M. D., Professor of Medicine and Interim Dean, WVU School of Medicine; "Hospital-Acquired Pneumonia"—Ronica Kluge, M. D., Professor of Medicine, University of Texas Medical Branch, Department of Medicine, Galveston; "Tuberculosis in the Hospital" —Rashida Khakoo, M. D., WVU Associate Professor of Medicine, Division of Infectious Diseases;

California Speaker

"Infections in the Compromised and Immunosuppressed Patient"—Lowell Young, M. D., Professor of Medicine, Division of Infectious Diseases, University of Southern California, Los

Shown in the left photo is Gary A. Banas (center), Akron (Ohio) attorney, speaker for the Physicians' Session of the 16th Mid-Winter Clinical Conference held in January in Charleston. The session was entitled, "The Doctor, Quality Control and Professional Liability." With Banas are John F. Wood (left), Huntington attorney, and Dr. Jack Leckie, also of Huntington, panelists. On the right are panelists Tom Auman (left), Director of Professional Liability, McDonough Caperton Shepherd Association Group, Charleston; and attorney Fred Bockstahler, Director of Patient Affairs, Charleston Area Medical Center. Not shown is panelist James C. Crews, CAMC President.

Angeles; "In-Hospital Staphylcoccal Infections" —Chatrchai Watanakunakorn, M. D., Professor of Internal Medicine, College of Medicine, Northeastern Ohio University; and "Current Concepts of the Pathogenesis and Rational Measures for Prevention of Infection due to Intravascular Devices"—Dennis G. Maki, M. D., Professor of Medicine, Section of Infectious Diseases, University of Wisconsin.

For registration and additional information concerning either meeting, telephone the WVU Office of Continuing Medical Education at (304) 293-3937.

Chapter Plans 16 Papers For April Meeting

"Recent Advances in Treatment of Headaches in Children" will be among some 16 papers to be presented during the 31st annual scientific assembly of the West Virginia Chapter, American Academy of Family Physicians.

The meeting will be held April 15-17 in Morgantown at the Lakeview Inn and Country Club.

The talk on headaches in children will be given Sunday morning, April 17, by Arnold D. Rothner, M. D., Chief, Section of Child Neurology, The Cleveland Clinic Foundation.

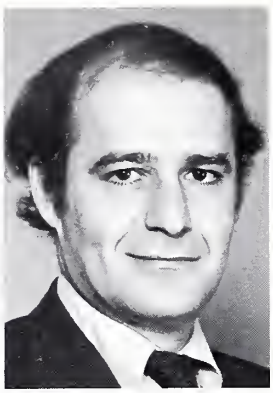
In addition to the concluding Sunday morning session, scientific sessions also will be held Friday morning and afternoon, and Saturday morning and afternoon.

Senile Dementia

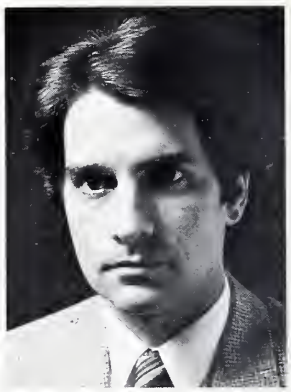
Some of the other speakers will be James T. Hartford, M. D., Associate Professor and Chief, Geriatric Psychiatry, University of Cincinnati Medical Center, on "Senile Dementia" (Sunday morning); Thomas Roth, Ph.D., Director, Sleep Disorders and Research Center, Henry Ford Hospital, Detroit, "Now I Lay Me Down to Sleep . . . Insomnia" (Saturday morning); and Joseph M. Pitone, D.O., Assistant Professor of Medicine, Department of Nephrology and Hypertension, University of Medicine and Dentistry of New Jersey, New Jersey School of Osteopathic Medicine; and Head, Subsection, Department of Nephrology and Hypertension, John F. Kennedy Memorial Hospital, Stratford (New Jersey) Division, "Hypertension Treatment for Family Physicians" (Saturday afternoon).

Arnold D. Rothner, M. D.

James T. Hartford, M. D.



Thomas Roth, Ph.D.



Joseph M. Pitone, D. O.

Other subjects to be discussed will include physician exercise and fitness; the impaired physician; office management; peptic ulcer disease; low back pain; beta blockers; thrombolytic therapy in venous thromboembolic disease; and rheumatology.

(See story in the February issue of *The Journal* for a complete list of speakers and topics.)

The program is acceptable for 18 and one-half Prescribed hours by the AAFP, and is approved for the same number of hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

Other Activities

The Chapter's House of Delegates will hold a noon luncheon meeting on Friday, and the Board of Directors will meet at 6 P. M. Thursday, April 14, and 1 P. M. Sunday. The annual banquet session is scheduled for 7:30 P. M. Saturday.

A breakfast meeting at 7 o'clock Sunday will be held by the Board of Directors of the Family Medicine Foundation of West Virginia.

Family Physicians will be welcomed to the scientific assembly by Dr. Robert D. Hess of Clarksburg, President.

WVU Charleston Geriatric Program March 16

Geriatric Update '83, a half-day continuing medical education program, will be held in Charleston on Wednesday afternoon, March 16.

The meeting site will be the West Virginia University Medical Center Education Building at 3110 MacCorkle Avenue, S.E.

By attending this program, participants will be able to determine effective usages of drugs and multiple drugs in care of the elderly patient, identify depressive states in the elderly, and understand current concepts in sleep patterns in the aged patient.

Faculty members will be: Mary Beth Gross, Pharm. D., Assistant Professor of Clinical Pharmacy, WVU Charleston Division: Albert Heck, M. D., Clinical Associate Professor of Neurology, WVU Charleston Division: Donald S. Robinson, M. D., Chairman, Department of Pharmacology, and Professor of Pharmacology and Medicine, Marshall University School of Medicine; and Thomas Roth, Ph.D., Director, Sleep Disorders and Research Center, Henry Ford Hospital, Detroit.

The program is approved for four credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

For additional information contact WVU Conference Services at (304) 347-1242.

Continuing Education Activities

Here are the continuing medical education activities listed primarily by the West Virginia University School of Medicine for part of 1983, as compiled by Dr. Robert L. Smith, Assistant Dean for Continuing Education, and J. Zeb Wright, Ph. D., Coordinator, Continuing Education, Department of Community Medicine, Charleston Division. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of The Journal.)

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the Morgantown, Charleston and Wheeling campuses. Further information about these may be obtained from: Division of Continuing Education, WVU Medical Center, 3110 MacCorkle Avenue, S. E., Charleston 25304; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 2000 Eoff Street, Wheeling 26003.

(continued on next page)

Shown in the left photo are, from left, Drs. Tony C. Majestro, Charleston orthopedic surgeon, and Frank C. McCue III of Charlottesville, Virginia, who spoke to physicians on sports medicine during the recent Mid-Winter Clinical Conference in Charleston. Doctor McCue also was the speaker for the Friday evening public session on medical care for the athlete. Doctor Majestro presided at the public session. On the right, Dr. James W. Kessel (left) of Charleston, speaker on trauma transport, chats with Dr. and Mrs. J. C. Huffman of Buckhannon.

March 16, Charleston, Geriatric Update '83

March 18, Charleston, 10th Annual Newborn Day

March 25-26, Morgantown, Infection Control Workshop

March 28-29, White Sulphur Springs, Symposium on Tumors for the Orthopedic Surgeon

April 28, Wheeling, Balance Disorders

April 29, Charleston, Research Day

April 29-30, Morgantown, Orthopedic Reunion Days

May 7, Charleston, Outpatient Infectious Diseases

May 12-13, Morgantown, Health Officers Conference

June 3-4, Morgantown, Anesthesia Update '83

June 4, Charleston, 10th Annual Wildwater Conference — Medical & Surgical Update

Regularly Scheduled Continuing Education Outreach Programs from WVU Medical Center/ Charleston Division

Buckhannon, St. Joseph's Hospital, first-floor cafeteria, 3rd Thursday, 7-9 P. M. — March 17, "Thyroid Dysfunction: Diagnosis and Management,' Richard Kleinmann, M. D.

April 21, "Prenatal Disorders and Congenital Anomalies," R. Stephen S. Amato, M. D.

May 19, "Evaluation of Infertility and Frequent Spontaneous Abortions," Bruce L. Berry, M. D.

Cabin Creek, Cabin Creek Medical Center, Dawes, 2nd Wednesday, 8-10 A. M. — March 9, "Overall Outpatient Management of Renal Dysfunctions," Mary Lou Lewis, M. D.

Gassaway, Braxton Co. Memorial Hospital, 1st Wednesday, 7-9 P. M. — March 2, "Enteral Alimentation," Brittain McJunkin, M. D.

April 6, "Clinical Intervention in Drug & Alcohol Abuse," Thomas Haymond, M. D.

Madison, 2nd floor, Lick Creek Social Services Bldg., 2nd Tuesday, 7-9 P. M. — March 8, "Drug & Alcohol Abuse: Intervention Strategies," Thomas Haymond, M. D.

Oak Hill, Oak Hill High School (Oyler Exit, N 19) 4th Tuesday, 7-9 P. M. — March 22, "End-Stage Renal Disease," Mary Lou Lewis, M. D.

April 26, "Adolescent Sexuality: Recognizing & Treating Pathological Behavior," T. O. Dickey, M. D.

Welch, Stevens Clinic Hospital, 3rd Wednesday, 12 Noon-2 P. M. — March 16, "Protocols for Treating Poisonous Snake Bites," David O. Wright, M. D.

April 20, "Emotional Trauma of Cancer," Sr. Frances Kirtley, R.N., and Sue Warren, M. D.

Whitesville, Raleigh-Boone Medical Center, 4th Wednesday, 11 A. M.-1 P. M. — March 23, "Hypertension Update: Diagnosis & Management," Stephen Grubb, M. D.

April 27, "Obesity: Emotional Factors in Compliance," John Linton, Ph.D.

Williamson, Appalachian Power Auditorium, 1st Thursday, 6:30-8:30 P. M. — March 3, "Suicide Intervention," Martin Kommor, M. D.

Review A Book

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication.

Basic and Clinical Pharmacology, by Bertram G. Katzung, M. D., Ph.D. 815 pages. Price $23.50. Lange Medical Publications, Los Altos, California 94022. 1982.

Nine Months' Reading: A Medical Guide for Pregnant Women, 3rd Edition, by Robert E. Hall, M. D. 178 pages. Price $13.95. Doubleday & Company, Inc., 245 Park Avenue, New York, New York 10167. 1983.

Living With Herpes, by Deborah P. Langston, M. D. 198 pages. Price $7.95. Doubleday & Company, Inc., 245 Park Avenue, New York, New York 10167. 1983.

Council Acts On Trauma Centers, Loan Fund

The State Medical Association's Council, at its January 16 meeting, endorsed the concept of designating West Virginia hospitals as trauma centers, following the criteria of the American College of Surgeons.

The action was taken following a presentation by Dr. Frederick M. Cooley of Charleston, Director, Emergency Medical Services of the State Health Department.

Doctor Cooley proposed that the State Health Department be empowered to designate West Virginia hospitals as trauma centers following application by an interested hospital and a site inspection visit to the hospital.

The Council also unanimously sanctioned contributions to the Clark K. Sleeth Medical

Speakers for the Saturday afternoon session on pediatric topics during the Mid-Winter Clinical Conference are shown with Dr. Herbert H. Pomerance (second from right) of Charleston, who presided. They are, from left, Drs. Martin R. Klemperer and Roberta Gray, both of Huntington, and R. Stephen S. Amato of Morgantown. In the right photo, Dr. Stephen L. Sebert (left) of Fairlea (Greenbrier County), has a conversation with Dr. William O. McMillan, Jr., of Charleston, member of the Program Committee.

Dr. William H. Nelson of Farmington, Connecticut, a psychiatrist who was a speaker for the Sunday morning session of the Mid-Winter Clinical Conference, is shown in the left photo. In the right photo, the other Sunday morning speakers go over the program with Dr. John W. Traubert (center) of Morgantown, who presided. They are Drs. Robert C. Touchon, left, Huntington cardiologist, who talked on calcium channel blockers, and George W. Weinstein, Morgantown ophthalmologist, whose subject was lens replacement.

Student Loan Fund in memory of the late Doctor Sleeth, former Dean of the West Virginia University School of Medicine, who died last November. Checks may be made payable to the "WVU Foundation," and it is suggested that the following be written in the lower left corner: "This contribution for the Clark K. Sleeth Medical Student Loan Fund." Checks may be sent to Dr. David Z. Morgan, Associate Dean of the WVU School of Medicine, Morgantown 26506.

In other action, Council:

—Heard an update on the Association-endorsed professional liability insurance program with CNA of Chicago as the carrier by Dr. Jack Leckie of Huntington, Chairman of the Association's Committee on Insurance.

—Elected to honorary membership, after appropriate component society action, Dr. Lysle T. Veach of Petersburg.

—Heard a review by staff members Robert F. Bible, Staff Counsel, and Charles R. Lewis, Executive Secretary, of medicine-related legislation introduced to date in the State Legislature.

—Elected or re-elected the following as nucleus members of the West Virginia Political Action Committee Board: Dr. Stephen D. Ward of Wheeling, First Congressional District; Dr. John L. Fullmer of Morgantown, Second Congressional District; Dr. Joseph T. Skaggs of Charleston, Third Congressional District; Dr. Frank J. Holroyd of Princeton, Fourth Congressional District, and Dr. Thomas F. Scott of Huntington and Bible as ex officio members

An Open Letter

To West Virginia's Physicians and Others:

As the years add up, and one gets along in life, it's not uncommon for a wheel or two to come off—sometimes not only unexpectedly, but in a hurry. That's what happened to me in recent weeks.

As members of the Executive Committee, Council and some others were aware, through myself, Drs. Carl Hall and John Markey, discovery of a rectal-area malignancy led very quickly to a colostomy. The post-operative prognosis appears at this point (February 6) most favorable; I'm at home recuperating, and I feel great.

There is just no way in which I can ever express to you individually my gratitude for your prayers; your many cards; flowers; telephone calls to the hospital, the Association office and my home; and the visits to the hospital by a number of physicians and others.

Completely inadequate that it might be, this message to the members of the Association accordingly is the only way I feel I have of expressing the deep-felt gratitude of myself, Jane and all the other members of my family.

I must confess to a feeling, also, of humble pride in the concern and interest from every part of the state and the physician community. We certainly have always made it our first order of business, as a state office, to exert every bit of effort to make the Association what its constitution says it shall be—and I have new confidence, gained through an admittedly unexpected channel—that we at least are headed in a strong and correct direction.

Under the current circumstances, a renewed expression of gratitude also is in order for the other members of the headquarters staff—Custer Holliday, Bob Bible, Mary Hamilton, Sue Shanklin, Mary Sue Smalley and Beverly O'Dell.

As I have often said, excluding my own 12 years with the Association and the Medical Institute, this staff represents some 60 years of service, expertise and dedication to the State Medical Association, its members and the people of this state. In this day and time, that kind of situation is virtually unheard of.

Staff was aware in every detail of what I faced; what my limitations would be for at least a little while; and some shifting and increase in workloads. They haven't missed a beat, with Custer doing his usual super job with the Mid-Winter Conference and the others right in step.

I'm proud of, and grateful for, that kind of support. And by the time you read this, I expect—with my doctor's close direction, of course—to be for the most part back in the saddle and at least able to handle the major issues at hand.

God bless you one and all,

CHARLES R. LEWIS
Executive Secretary

representing the Council and the State Medical Association staff, respectively.

—Approved the payment of round-trip air fare for a representative to the meeting of the residents section at the annual meetings of the American Medical Association (pending final approval of a membership category for residents by the State Association's House of Delegates at the Annual Meeting next August).

—Approved the transfer of the Association employee benefit plan from the Connecticut Mutual Life of Hartford, Connecticut, to the Kanawha Valley Bank in Charleston.

—Heard comments by Dr. L. Clark Hansbarger, State Health Director, on the State Health Department budget, legislation sponsored by the Department, and the rationale behind the announced closing of Spencer State Hospital.

—Reconfirmed previous Council action in endorsing a collection service offered by I. C. System, Inc., of St. Paul, Minnesota.

Pain Killers Underutilized, AMA President Says

Physicians frequently underutilize pain medications for terminal patients, American Medical Association President William Y. Rial, M. D., said at a recent AMA conference on severe chronic pain. Every day, thousands of patients suffer unnecessarily because a drug is administered in inadequate doses or excessively long dosing intervals, he said.

Doctor Rial noted that patients often are reluctant to reveal the severity of their pain or to take narcotics. Hospital staffs and relatives often have a misguided concern that the terminally ill patient will develop a drug dependence, he said at the Conference on the Care of Patients with Severe Chronic Pain in Terminal Illness, which was co-sponsored by the U.S. Public Health Service.

"It is the responsibility of every physician and all others who serve patients to understand the dynamics of pain, to understand the pharmacologic activity of analgesics, and, most importantly, to work with and understand the needs of each patient and the family," Doctor Rial said at the conference in Washington, D. C.

The conference coincided with the reintroduction of a bill by Sen. Daniel Inouye (D, Hawaii) that would legalize heroin for use in relieving pain for terminal patients.

"I personally do not believe that legalizing heroin or making it more available is necessary for the treatment of patients," Assistant Secretary for Health Edward N. Brandt, Jr., M. D., told the AMA. "The other analgesics that are on the market are equally potent, and the new ones that are being developed are up to six times more potent than heroin."

Rescheduling heroin would lead to illegal trafficking and promote drug abuse that can ruin the lives of children and young adults, said Doctor Brandt, who was a speaker at the conference.

Clark K. Sleeth Memorial Started By AAFP

A Clark K. Sleeth, M. D., Memorial Fund has been established by the West Virginia Chapter, American Academy of Family Physicians through the Academy's Family Medicine Foundation of West Virginia.

The action was taken by the Academy at its January meeting in Charleston to honor the late Doctor Sleeth, a former Dean of the West Virginia University School of Medicine and the first Chairman of the WVU Department of Family Practice. Doctor Sleeth died last November 30.

Proceeds from the memorial fund will be channeled into the Foundation's regular programs, including support for family practice residency programs, family practice clubs for undergraduates, and student scholarships.

Checks should be payable to the Family Medicine Foundation of West Virginia, and sent to the Foundation at P. O. Box 7058, Cross Lanes, Charleston 25313-0058.

AMA Takes Strong Stand On Drunk Driving

The American Medical Association has noted its support of incentive grants to states that voluntarily improve their laws and traffic safety programs to curtail drunk driving accidents. Enacted by the last Congress, PL 97-364 will "encourage and enable the states to increase and improve their efforts to reduce the number of drunk drivers on the road," the AMA said recently in comments on the advance notice of proposed rule-making to implement the law.

To be eligible for the supplementary funds, the states must (1) suspend the driver's licence for at least 90 days on the first conviction, (2) sentence repeaters to at least 48 hours in jail or to 10 days' community service, (3) recognize

0.10-per cent blood alcohol concentration as the legal measure of intoxication, and (4) increase efforts to enforce alcohol-related traffic laws and to let the public know of such enforcement.

A state may participate in the program for a maximum of three years. The federal share will diminish from 75 per cent in the first year, to 50 per cent in the second year, and to 25 per cent in the third year. A total of $25 million has been authorized for fiscal year '83, and $50 million each for fiscal year '84 and fiscal year '85.

AMA Leader Speaks

"Let's get drunk drivers off the road," AMA Executive Vice President James H. Sammons, M. D., said at a recent meeting of the Alliance Against Intoxicated Motorists (AAIM) in Chicago. "Drunk drivers are responsible for an epidemic of tragic human carnage on our roads and highways," said the AMA leader, who stated that about 27,500 Americans are killed and about 700,000 people are seriously injured in alcohol-related traffic accidents each year.

"If you visited the emergency room of a community hospital during the late night or early morning hours on any Friday or Saturday, when drunk drivers are most prevalent, you would probably conclude that our roads and highways have become a battlefield. In that emergency room, you would find physicians and other health professionals desperately trying to save the maimed victims of a drunken driver."

A featured speaker on the program was nationally syndicated advice columnist Ann Landers, who declared that drunken driving is a "national disgrace." "We have got to do something about the judges who keep letting these guys off," said Landers, who is a member of the President's Commission on Drunk Driving. She supported state efforts to reduce alcohol-related accidents among young people by raising the drinking age from 18 to 21 years of age.

Past AMA Action

Through the years, the AMA House of Delegates has taken a number of actions to stop drunk driving. In 1960, the House recommended that a blood alcohol level of 0.10 per cent should be accepted as *prima facie* evidence of legal intoxication. In 1981, it called on state and specialty societies to seek enactment of more stringent drunk driving laws in all the states.

At the meeting last December in Miami Beach, the House directed the AMA to provide even stronger support for state and federal legislation.

Medical Meetings

March 4-6—Am. Medical Student Assoc., Cleevland.

March 5-12, Canadian Am. Medical Dental Assoc., Vail, CO.

March 10-15 — Am. Academy of Orthopedic Surgeons, Anaheim, CA.

March 20-24—Am. College of Cardiology, New Orleans.

April 7-8—WV Chapter, Am. Academy of Pediatrics, Beckley.

April 11-14—Am. College of Physicians, San Francisco.

April 15-17—WV Chapter, AAFP, Morgantown.

April 16-21—Am. Academy of Pediatrics, Philadelphia.

April 17-21—Am. Urological Assoc., Las Vegas.

April 17-22—Operative Treatment of Fractures & Nonunions (Johns Hopkins University), Hot Springs, VA.

April 18-22—Am. Roentgen Ray Society, Atlanta.

April 22-24—Medical Staff Leadership Seminar (Southern Medical Assoc.), Hilton Head, SC.

April 23—WV Diabetes Assoc., Charleston.

April 24-28—Am. Assoc. of Neurological Surgeons, Washington, D. C.

May 4-7—WV Chapter, Am. College of Surgeons, White Sulphur Springs.

May 6-8—Southern Medical Assoc. Regional Postgraduate Conference, Lexington, KY.

May 8-12—Am. College of Obstetricians & Gynecologists, Atlanta.

May 13-14—Topics in Cardiovascular Diseases (Am. Heart Assoc.), Baltimore.

May 26-28—Am. Assoc. of Genitourinary Surgeons, White Sulphur Springs.

June 19-23—Annual Meeting of AMA House, Chicago.

Aug. 25-27—116th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

Sept. 29-Oct. 2—Am. Society of Internal Medicine, San Francisco.

Oct. 16-21—Am. College of Surgeons, Atlanta.

Nov. 6-9—Scientific Assembly, Southern Medical Assoc., Baltimore.

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WVU Medical Center
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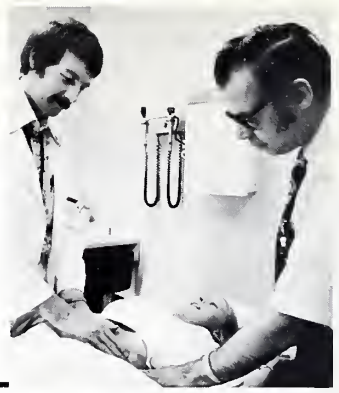

Compiled from material furnished by the Medical Center News Service, Morgantown, W. Va.

Medical Graduate Return Rate Above National Average

West Virginia University is returning a good percentage of its medical graduates to practice in West Virginia, in numbers better than the national average, according to Interim Dean Robert H. Waldman, M. D., of the School of Medicine.

Doctor Waldman's comments were in response to concerns, in a time of major state financial difficulties, over whether the state's medical schools are meeting its health manpower needs.

"It makes us very unhappy to hear it said that West Virginia University is not returning its medical graduates to West Virginia to practice medicine," Doctor Waldman said.

'Proven Track Record'

"Furthermore, unlike some medical schools, we are not just talking about our good intentions. We're not just planning to produce doctors for West Virginia; we have a proven track record of graduates remaining in West Virginia to practice."

Doctor Waldman said WVU medical graduates "are also choosing medical specialties most widely needed in a rural state such as ours, and many are practicing in areas of the state that have been short on doctors."

Nationwide, less than 40 per cent of all physicians are practicing in the state where they received their M. D. degrees. The figure is even lower among most small states.

"Against these figures, West Virginia University stands up well," Doctor Waldman said. "Of the 766 WVU medical students who earned their M. D. degrees during the 1970s, 41.1 per cent are practicing in West Virginia.

"The figures look even better when you consider the past five years: except for a slight lag in 1978, the percentage of our graduates remaining in West Virginia has been near 50 per cent since 1974."

The percentage of West Virginia physicians who are WVU graduates increased by 89.5 per cent between 1972 and 1982.

WVU graduates who remain in West Virginia also tend to choose to specialize in the areas of greatest need. The top five specialties of WVU medical graduates who are practicing in West Virginia are internal medicine, family practice, general surgery, psychiatry, and obstetrics and gynecology.

Nearly 60 per cent of the WVU medical graduates who chose family practice or general practice as their specialty have remained to practice in West Virginia.

In addition, physicians who do their post-graduate training at WVU—whether or not they earned their M. D. degree in West Virginia—tend to remain in the state.

Doctor Gutmann Serving On National Board

Ludwig Gutmann, M. D., Chairman of Neurology, has accepted an invitation to serve on the National Board of Medical Examiners.

The board designs and regularly updates examinations used in the licensing of physicians and national testing of medical students. About 80 per cent of all U. S. medical graduates are licensed to practice through NBME certification, and 52 of the 55 licensing authorities in the U. S. and Canada accept National Board certifications without requiring further examination.

Doctor Gutmann will serve on the Medicine Test Committee for Part II, which develops the content of National Board examinations for medical students in medicine and neurology.

NBME test committees include more than 100 men and women chosen from among prominent members of medical faculties throughout the U. S. and Canada. They were described as "the best qualified leaders in medicine" by Edithe J. Levit, director of the NBME, which was established in 1915 and has principal offices in Philadelphia.

Doctor Gutmann joined the WVU medical faculty in 1966.

WHEELING HOSPITAL

Medical Park, Wheeling WV 26003

Announces The Third Continuing Education Course
On

BALANCE DISORDERS

Thursday, April 28, 1983

Credits: Approved for 7 Credit Hours Category I for the Physician's Recognition Award of the AMA. Acceptable for 7 Prescribed Hours by the American Academy of Family Physicians.

Course: This course is designed for the family practitioner and the many various specialists seeking better understanding and improved competence in the diagnosis and management of the patient with any form of dizziness or disequilibrium. The registration fee is $30.00 and includes the course-related materials, luncheons, refreshments and cocktails. The topics covered will include:

Topics: Bone Marrow Examination, Clinical Application; Plasma Cell and Blood Protein Disorders; Auditory Brainstem Evoked Potentials, ENG, Impedance Audiometry, Application to Clinical Otology; Management of Otitis Media in Children; Surgical Management of Vertigo; Recent Advances in Anti-Microbial Therapy; Hyperlipidemia; Parkinsonism, Plus Syndrome; Hypoglycemia; Clinical Management of Acute Hypersensitivity Syndrome.

Chairman: **Hong I. Seung, M.D.**, Clinical Assistant Professor, Otolaryngology-Head and Neck Surgery, West Virginia University School of Medicine, Morgantown, West Virginia. Senior Staff, Wheeling Hospital and Ohio Valley Medical Center, Wheeling, West Virginia

Speakers: **Joseph R. Bianchine, M.D.**, Professor and Chairman, Department of Pharmacology; Professor of Medicine, Ohio State University, College of Medicine, Columbus, Ohio.

Thaddeus S. Danowski, M.D., Clinical Professor of Medicine, University of Pittsburgh, School of Medicine; Director of Medicine, Shadyside Hospital, Pittsburgh, Pennsylvania.

Heinz F. Eichenwald, M.D., Professor and Chairman, Department of Pediatrics, University of Texas, Health and Sciences Center, Dallas, Texas.

Michael Glasscock III, M.D., Clinical Professor of Otolaryngology, Vanderbilt University, School of Medicine, Nashville, Tennessee.

Bong H. Hyun, M.D., D. Sc., Professor of Pathology, Rutgers Medical School; Director, Department of Pathology, Muhlenberg Hospital, Plainfield, New Jersey.

Lodging: Overnight Accommodations: Physicians should directly contact the reservation manager of hotel or motor inn of their choice. Suggestions: Howard Johnson's 1-800-654-2000 and Wheeling Inn (304) 233-8500. For golf reservations at Oglebay Park's Speidel Course, call (304) 242-3000, Extension 156. For tennis reservations, (304) 242-3770 (indoor, Wheeling Park) or (304) 242-3000, Extension 139 (outdoor, Oglebay Park). For further information contact Dr. Elliott at Wheeling Hospital (304) 242-7870.

Registration Form

BALANCE DISORDERS

Thursday, April 28, 1983

Name _____ Specialty _____

Address _____ City _____ State _____

Registration fee is $30.00. Please make checks payable to Wheeling Hospital and mail with this form to Terry Elliott, M.D., Continuing Medical Education, Wheeling Hospital, Medical Park, Wheeling, WV 26003.

Third-Party News, Views and Program Concerns

Health Care Competition Policy On Horizon

The Reagan Administration continues to move toward its long-awaited proposal to inject more competition into the health care economy, the American Medical Association has observed.

Speaking before a recent national health maintenance organization (HMO) policy conference in Washington, White House health consultant David A. Winston said he had reason to believe a competition policy would be introduced "very soon." The annual meeting was sponsored by the Group Health Association of America and the American Association of Foundations for Medical Care.

Winston, an unpaid special consultant with responsibility for coordinating the development of an Administration strategy for health care reform, predicted that the proposal would include a so-called "tax cap," limiting the dollar amount of health care benefits that are nontaxable to the employee, and mandatory cost sharing for certain Medicare patients.

He was less optimistic about the proposal's chances for enactment, saying he could not predict whether such a proposal would pass. He was convinced, however, that top-level Administration officials were committed to making the health care system more responsive to price.

Proposal Lags

Discussing why the Administration's plans for a so-called "pro-competition" proposal had lagged for two years, Winston said the Administration assessment was that "almost anything would irritate almost everyone."

For a period, he said, "we thought seriously that the smartest political thing" was to do nothing. More recently, data on current and projected health care expenditures made the Administration take notice of a pressing need for changes, he added.

Winston said the $56.4 billion spent on Medicare in 1982 year would grow, by conservative estimate, to $100 billion by 1987 if no reforms were enacted. Six weeks ago, health care experts, briefing the President and other top Administration officials, estimated that total health care expenditures in the nation would grow to $798 billion by 1990 if the current system was allowed to stand.

Acknowledging that the Administration was supporting an unpopular proposal, Winston said everyone would suffer "a certain amount of pain" and undergo constraints to accomplish the long-term goal of helping consumers become more prudent buyers of health care.

AMA Supports Streamlined FDA Drug Approval

The American Medical Association has gone on record as supporting proposed rule changes that would streamline U. S. Food and Drug Administration approval of new drugs. A number of the provisions in the proposed rule are close to draft amendments to the Food, Drug, and Cosmetic Act that were developed by the AMA in 1977, and also are similar to recommendations of the Commission on the Federal Drug Approval Process.

The AMA has long been concerned about the so-called "drug lag." AMA Executive Vice President James H. Sammons, M. D., said in a letter to FDA Commissioner Arthur Hull Hayes Jr., M. D. Because of the FDA's time-consuming approval procedures, important new drugs reached the market in foreign countries well before they were available in the United States. By eliminating unnecessary regulation requirements, the proposed FDA rule changes will make drugs available for patients "in the shortest possible time consistent with safety and effectiveness," Doctor Sammons said in the letter.

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County Societies

HARRISON

Ms. Dexanne B. Clohan. Assistant Director. Department of Congressional Relations of the American Medical Association in Washington. D.C., and Charles R. Lewis of Charleston were keynote speakers for the 1983 Health Legislation Forum held January 6 in Clarksburg by the Harrison County Medical Society.

Lewis is Executive Secretary of the State Medical Association.

The forum. which was held at the Sheraton Inn. was co-sponsored by the Auxiliary.

State Senator Gino R. Colombo. Clarksburg. and Senator Jean Scott Chace. Weston. and State Delegate Percy C. Ashcraft II. Clarksburg. participated in the forum. Also present were representatives of local hospitals. community health and other agencies.

The forum was attended by 80.—Gaspar Z. Barcinas. M. D.. President.

* * *

WESTERN

The Western Medical Society met on January 18 in Ripley at Jackson General Hospital.

The guest speaker was Dr. Paul D. Saville of Charleston. Clinical Professor of Medicine at West Virginia University School of Medicine. who spoke on non-steroidal and anti-inflammatory drugs.

The Society approved the drafting of a letter in protest of the announced closing of Spencer State Hospital to be sent to Governor John D. Rockefeller IV; Dr. L. Clark Hansbarger. State Health Director: Charles R. Lewis. Executive Secretary. State Medical Association. and the West Virginia Congressional delegation.—Ali H. Morad. M. D.. Secretary.

* * *

McDOWELL

David H. Cleland of Charleston was the guest speaker for the meeting of the McDowell County Medical Society on January 12 in Welch at Stevens Clinic Hospital.

Cleland is Medical Relations Officer for the Disability Determination Service. West Virginia Division of Vocational Rehabilitation. He spoke to the Society on the changes in disability determination over the past 10 to 20 years. and clarified the physician's role and criteria used to determine if a person is disabled.—John S. Cook. M. D.. Secretary.

* * *

FAYETTE

Dr. Saghir Mir. Montgomery orthopedic surgeon. was the speaker for the meeting of the Fayette County Medical Society on January 5 at Montgomery General Hospital.

Doctor Mir spoke on "Advances in Orthopedics."

The Society approved sending a letter to Governor John D. Rockefeller IV asking for support of State Medical Association-endorsed legislation to limit awards in malpractice suits.—Serafino S. Maducdoc. Jr., M. D.. Secretary-Treasurer.

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Book Review

STAND TALL! — THE INFORMED WOMAN'S GUIDE TO PREVENTING OSTEOPOROSIS—Morris Notelovitz, M. D., and Marsha Ware. 208 pages. Price $12.95. Triad Publishing Company, Inc., P. O. Box 13096, Gainesville, Florida 32604. 1982

The overtones of the Marine Corps in the title of this book are misleading. It is a book written to explain what is known about osteoporosis and its prevention and management, primarily for a lay audience but also for health professionals. There are descriptions of bone anatomy and physiology, and information on the variety of factors that can affect bone resorption and deposition. The sites where osteoporosis occurs, and why, are covered. There also is instruction on how it can be measured, and there are chapters on how to prevent or manage the condition together with some illustrative case histories.

At this time it isn't feasible to use the research methods that can accurately measure bone density on a regular screening basis; to wait for the first fractures to occur is much too late. What this book has to offer is a discussion of the risk factors and the ways that life style can be altered to reduce the likelihood of developing the condition. From a review of the case reports and the way the histories taken are used to direct management strategies it is clear that the approach has a wide potential nationwide, in primary care, for women from the age of 30 up.

I can therefore heartily recommend this book. One of its strengths is its lucid writing and the care taken not to overstate what is known or can be done. I therefore hope it will be widely and well used by primary care practitioners and their patients.—R. John C. Pearson, M.B., M.P.H.

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The West Virginia Medical Journal

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Pain And Its Pharmacologic Manipulation

CHARLES D. PONTE, R.Ph., Pharm.D.
Assistant Professor of Clinical Pharmacy, School of Pharmacy, and Assistant Professor of Family Practice, School of Medicine, West Virginia University Medical Center, Morgantown

Pain is a complex, subjective phenomenon and difficult to evaluate. The perception of an unpleasant sensation and the emotional reaction to the sensation constitute the pain experience.

The two broad categories of pain, acute and chronic, are distinct entities requiring different approaches in treatment. Chronic-pain management requires regularly scheduled doses for optimal benefit.

The strong narcotic analgesics should be employed when acute or chronic pain is most severe and cannot be controlled effectively with mild analgesics. Recent controlled trials have shown that neither Brompton's Cocktail nor heroin has an advantage over oral morphine solution.

Newer agents may have less abuse or addiction potential than conventional strong narcotic agents. Nalbuphine and butorphanol are as effective as morphine and may cause fewer side effects than other narcotic analgesics.

Pain will touch the lives of all individuals at some point. It often is regarded as an integral part of human existence. Only during the last 50 years have the types and forms of pain and their functions been studied adequately. Despite this recent investigation, pain literature still may lack scientific content. Many anecdotal reports exist, and the subjectivity of pain makes it a very difficult area to study.

There exists no universally accepted system of pain measurement. Pain often is perceived as evidence of ill health, and can cause feelings of anxiety and fear of the unknown. This paper will attempt to delineate briefly the nature of the pain experience, its forms and its treatment.

There are generally two components to pain.[1] First, there is the perception of an unpleasant sensation. The perception depends upon the type and severity of the pain stimulus. The pain experience from a crush injury to a finger will undoubtedly be different than that from a pin prick to the same finger. The second component of pain, and equally important, is the emotional reaction. Many cultural, psychological and physical factors have input into the reaction. Scandinavians and Orientals are considered very stoic about pain whereas Mediterranean peoples may be more expressive.

Acute versus Chronic Pain

The two broad categories of pain, acute and chronic, are distinct entities. Their causes may be different, requiring different approaches in treatment.[1-7]

Acute pain may be perceived as nature's way of alerting us that there is something wrong with the body. The patient expects that the pain will disappear rapidly. The pain also may be rationalized as being part of the healing process.

During acute pain, certain physiological parameters change reflexively. Cardiac rate, blood pressure, respiration, peripheral blood flow, palmar sweating, pupillary diameter and muscle tension can all increase. These parameters similarly change when anxiety is experienced.

Chronic pain can be considered a distinct disease entity. It cannot be rationalized as part of the healing process, and serves no biological purpose. It imposes great emotional, physical, economic and social demands on the patient, his family and society.[2] Because of its discouraging and often unrelenting nature, chronic pain often creates feelings of helplessness and hopelessness in the patient. Because of their preoccupation with pain, chronic-pain patients may become isolated from their surroundings. The classic example is cancer pain. Other causes of chronic pain are found in Table 1.

Cancer patients generally fear dying in pain. Most cancer patients do not experience severe pain, and most can be treated effectively with minimal sedation.[5]

Lipman believes that chronic pain exists in a continuum between an aching and agonal phase, and that most patients can function with a dull background ache.[8] He feels that chronic pain comprises a psychological component consisting of anxiety and depression in addition to the physical component. Both components should be treated if adequate symptom control is to be achieved. The Figure illustrates the psychological components of pain and their effects on pain perception.

Acute and chronic pain, as noted, require different treatment modalities.[9-11] Table 2

TABLE 1

Examples of Chronic Pain

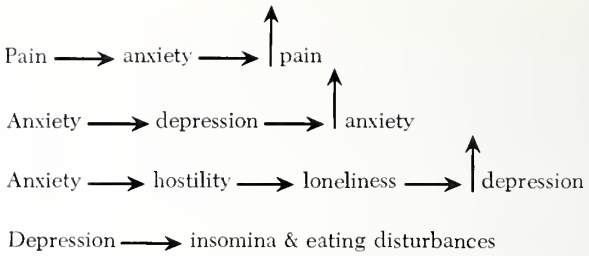
1. Cancer
2. Angina pectoris
3. Inflammatory Disease—arthritis
4. Headache
5. Low back pain
6. Phantom limb pain
7. Burn treatment
8. Continued bone marrow aspirations

From—Dolan M: *Am Pharm* 1978; (1812):8-13.

TABLE 2

Acute Pain	*Analgesic*
Mild	Aspirin (Acetaminophen)
Moderate	Aspirin plus Codeine
Severe	Morphine
Chronic Pain	
Aching Phase—Non-narcotic analgesics	
Agony Phase—Narcotic analgesics	
Adjunctive Therapy—antianxiety agents, phenothiazines, antidepressants, corticosteroids, antiemetics	

From—Lipman AG: *Am J Hosp Pharm* 1976; 32:270-276.



From—Lipman AG: *Am J Hosp Pharm* 1975; 32:270-276.

Figure.

illustrates the prototype analgesics required to treat different types of pain. Adjunctive therapy has a place in the management of chronic pain and will be discussed later.

Analgesics for Mild-to-Moderate Acute Pain

Most patients who experience acute pain can be managed effectively with drugs such as aspirin or aspirin-containing combinations. The pain is self-limited and does not require more potent narcotic analgesics. Aspirin in combination with pentazocine (Talwin) or codeine/oxycodone appears to be more effective than aspirin alone, and probably should be the preferred combination for moderate acute pain.[12]

Aspirin remains the drug of choice for mild acute pain. It also can be effective for mild cancer pain. An appropriate starting dose is 650 mg orally. A higher dose of 975 mg can be used safely. Higher doses may increase the duration of analgesia but side effects also may be increased. The average duration of effect is 4.5 hours. The drug may act peripherally on pain receptor mechanisms, block the generation of impulses at chemoreceptor sites for pain, or interfere with the production of prostaglandins. Common side effects include nausea, epigastric pain, vomiting, occult GI bleeding and platelet inhibition.

Acetaminophen (Tylenol) should be used in patients who cannot tolerate aspirin, or where aspirin is contraindicated. The drug is equipotent to aspirin as an analgesic and antipyretic, and lacks significant gastrointestinal side effects. Nephrotoxic and hepatotoxic reactions are possible with large doses.

Propoxyphene (Darvon) is a weak analgesic which lacks antipyretic and anti-inflammatory properties. Its analgesic activity has not been demonstrated consistently in controlled trials.[13] The drug should not be considered an aspirin substitute in cases of aspirin intolerance. This drug has significant potential for abuse.

Pentazocine, Codeine

Pentazocine (Talwin) has an analgesic effect similar to aspirin and acetaminophen. The drug can produce bizarre central nervous system effects including hallucinations. The drug also has been associated with a significant addiction potential. The drug also may potentiate the effects of aspirin.[14]

Codeine, in equianalgesic doses, has effects similar to aspirin but lacks significant anti-inflammatory activity. It can cause narcotic adverse effects including gastrointestinal distress, vomiting, sedation, constipation and dizziness.

The non-steroidal, anti-inflammatory agents are more expensive than the usual drugs used to treat mild-to-moderate acute pain. They should be reserved for use when the usual drugs are ineffective, produce undesirable side effects or are contraindicated. These agents may produce a lower incidence of gastrointestinal side effects. A new agent, zomepirac sodium 100 mg (Zomax), is approximately equal to codeine sulfate 65 mg plus aspirin 650 mg in analgesic efficacy.

The use of analgesic combinations may be pharmacologically appropriate. The clinician can take advantage of drugs which exhibit different mechanisms of action. Aspirin with codeine would be a common example. Aspirin-phenacetin-caffeine combinations are without justification and should not be used. Many manufacturers currently are removing phenacetin and caffeine from their products.

Fixed-dose combinations have the disadvantage of reduced dosage flexibility, and their use should be discouraged. Their cost, increased adverse reactions and lack of efficacy should preclude their routine use.

Analgesics for Severe Pain

When acute or chronic pain is most severe and cannot be controlled effectively with either single or combination mild analgesics, strong narcotic analgesics must be used. The individual agents vary slightly both in their quantitative and qualitative effects, but the pharmacologic and therapeutic properties of these drugs are quite similar. Unlike the mild analgesics discussed, morphine and the other narcotic analgesics exhibit increased analgesia with higher doses.

Frequent side effects include gastrointestinal intolerance, sedation and vertigo. Gastrointestinal intolerance is often mistaken for a true allergic manifestation. A complete history of the nature of the reaction is needed for proper interpretation.

Respiratory depression is a serious consequence of narcotic analgesic use. This effect is dose-related and is the same for any narcotic at equianalgesic doses. Narcotics act on the respiratory center in the brain stem to reduce responsiveness to rises in pCO_2. Respiratory volume is depressed, followed by a decreased respiratory rate. However, despite severe respiratory depression, the patient may continue to breathe via hypoxic drive regulated by the carotid and aortic chemoreceptors. Supplemental oxygen support will eliminate the hypoxic drive and cause apnea.[1]

Tolerance will develop with continued use of these agents. A larger dose will be needed to produce a similar effect which smaller doses provided initially. Tolerance to adverse reactions also will develop at the same rate as to the analgesic effects. Therefore, increasing the dose will not increase the likelihood of developing adverse reactions.

The selection of a particular narcotic analgesic should be based upon several pharmacologic factors. These include oral effectiveness, duration of action, degree of effect on smooth muscle, route of metabolism, and individual variation in patient response.[1,3]

Narcotic analgesics are used commonly in suboptimal doses.[15] This may occur because of fear on the part of prescribers of eliciting tolerance and dependence. Patients who experience and suffer from physiological pain respond differently to narcotics than individuals seeking euphoric effects.

PRN vs. Regularly Scheduled Doses

Chronic pain management and prevention require careful titration of doses of an appropriate analgesic. It is easier to prevent pain than to treat it. Higher doses of analgesics usually are required to alleviate pain once it has occurred.

Acute-, severe- or chronic-pain patients may be treated with narcotic analgesics on an "as needed" basis. Such a practice may mean more pain for the patient. He may be hesitant to ask for analgesics for fear that this is a sign of a weak or bothersome patient. Continual requests for pain medication can reinforce addictive behavior. Nurses may be hesitant to administer "prn" doses for fear of dependency since pain is a subjective experience and is difficult to assess.[1] "As needed" orders should be discouraged from routine use when dealing with

chronic-pain patients. Regularly scheduled doses may be required for severe acute pain management for 24 to 48 hours.

Once the pain has been controlled, narcotic requirements will usually lessen, and lower doses can be used for maintenance therapy. The patient should be started on a moderate dose of a narcotic analgesic, and the dose should be lowered every several days. The optimal dose is between the lowest dose which was associated with pain alleviation and the dose where the pain returns. Such dosage titration will lower the potential for addiction and sedation.[8]

Oral vs. Parenteral Administration

The oral route of administration is the preferred and most convenient way of administering medication.[4,14] This obviates the use of parenteral dosing with its associated patient discomfort and technical mode of administration.

Many narcotics are available in oral dosage forms. These agents should never be administered in the same dose as employed parenterally. Except for extremely severe pain, oral narcotics are effective unless the patient cannot absorb oral agents.

Meperidine (Demerol) is an effective oral agent when doses of 100-150 mg are administered. Morphine also is an effective oral drug when used in appropriate doses (60 mg orally = 10 mg parenterally).

Dosage Adjustments

Many chronically ill or older patients may experience deteriorating renal or liver function either as a consequence of their disease or from the aging process. Such patients may require dosage adjustments to avoid potential toxicity from prescribed medication. Patients should have their liver and/or renal function assessed periodically to avoid unnecessary problems.[1]

Cocktails

Brompton's Mixture originally was used at the Brompton Chest Hospital in England in 1952. The original formula consisted of morphine, cocaine, alcohol, syrup and chloroform water. This original formula has undergone many modifications by various individuals. The mixture now usually contains a narcotic analgesic, a CNS stimulant and alcohol in a flavored vehicle. A phenothiazine frequently is added as an antiemetic.

Recent controlled trials have shown that neither Brompton's nor heroin has an advantage over oral morphine solution. Results of a study comparing the Brompton's-type solution and a morphine solution indicated no significant difference in pain control or in the incidence of side effects.[16] It is apparent that none of the ingredients in the original formula enhances the analgesic effects of the narcotic.

The routine addition of phenothiazines to a narcotic analgesic should be discouraged. Narcotic-induced CNS depression, respiratory depression and orthostatic hypotension may be potentiated.

Adjunctive Therapy

A variety of drugs can be used with analgesics in the management of pain. These agents have particular benefit when used concomitantly in the treatment of chronic pain states.[8]

Phenothiazines may provide anxiolytic activity, and are useful in managing nausea which frequently occurs with the use of narcotic analgesics. Their sedative properties can be advantageous to both the patient and clinician. Depending upon the drug chosen, the anticholinergic, sedative, CNS and cardiovascular properties may be important considerations for a given patient.

Anticholinergic drugs should be used with caution. Side effects including blurred vision, dry mouth, urinary retention and constipation may be additive to concurrent analgesic medication.

Corticosteroids may have beneficial effects in the chronic-pain patient. These drugs may increase the sense of well-being and appetite. They also have proved beneficial in the management of hypercalcemia which is seen in many cancer patients.

Benzodiazepines may enhance night-time sedation, thereby alleviating the insomnia associated with chronic pain. The newer agents with shorter terminal half-lives, or which are not metabolized to active compounds, may be preferred in chronic-pain patients.

Tricyclic antidepressants may be beneficial in alleviating the reactive depression seen in cancer patients. Careful selection of an appropriate agent, with particular attention to sedative and anti-cholinergic properties, should be encouraged.

The Problem of Nausea and Vomiting

Nausea and vomiting frequently occur with the use of narcotic analgesics. Narcotics stimulate the chemoreceptor trigger zone in the medulla oblongata and enhance vestibular sensitivity. When phenothiazine antiemetics are not

helpful, an antihistamine can be added to the regimen. This may be very useful for the ambulatory patient when vestibular sensitivity contributes to the nausea.

Nausea and vomiting also can be caused by the disease process and the cancer chemotherapeutic regimens employed. Antiemetics should be given prior to the initiation of chemotherapy or radiation therapy in an effort to lessen the likelihood or severity of the resultant nausea and/or vomiting.

Newer Agonist-Antagonist Analgesics

In recent years, newer agents have been marketed which have claimed to have less abuse or addiction potential than the conventional strong narcotic analgesics. These drugs include pentazocine, nalbuphine (Nubain) and butorphanol (Stadol). These drugs potentially can cause respiratory depression; however, the magnitude of the respiratory depression does not appear to be enhanced with increasing doses.

These drugs also carry the potential to elicit opiate abstinence syndromes in patients physically dependent on narcotic analgesics. Nalbuphine is as effective as morphine at the appropriate doses. Its onset, peak and duration of action are approximately the same as morphine. Minimal hypotension in post-myocardial infarction patients has been noted. The drug also produces less nausea and vomiting than narcotic analgesics.[17]

Butorphanol appears to be equally as effective as morphine, but may be more sedating. The cardiovascular effects are uncertain and require further study.[18,19]

Conclusions

Pain is a human experience from which no one will escape. Only recently have researchers been able to elucidate the complex physical, psychological and biochemical interactions which make up the pain experience. The etiologic factors and type of pain should be elucidated before appropriate or adequate treatment can be initiated. The current armamentarium consists of many narcotic and nonnarcotic analgesics. When used properly, they are effective and safe drugs. The potential for addiction is minimal, especially when narcotic analgesics are used in the treatment of chronic pain.

Pain management requires individualized treatment. Plans should be formulated which employ the most rational agents for a particular set of patient circumstances. Through further basic research, newer agents will be developed which will have advantages over current agents. Cheaper, safer and more specific drugs will bring an added dimension to the control of pain in all of its forms.

General Prescribing Guidelines for the management of acute and chronic pain appear at the end of this article. These guidelines will offer one method of treating various pain states. The recommendation should aid the clinician in individualizing therapy for patients. Such an approach may alleviate both patient and prescriber apprehension.

Editor's Note: Here are the generic drugs and trade names (in parentheses) to which reference is made in this manuscript: pentazocine (Talwin); acetaminophen (Tylenol); propoxyphene (Darvon); zomepirac (Zomax); meperidine (Demerol); nalbuphine (Nubain); and butorphanol (Stadol).

General Prescribing Guidelines

Acute Pain — Orally Administered Medications

Situation 1 — *Mild Pain*

Aspirin/Acetaminophen 650 mg every 4-6 hours.

Do not *exceed* 975 mg per does (Little enhanced analgesia, increased toxicity).

Situation 2 — *Moderate Pain*

Aspirin/Acetaminophen *plus*
- 25 mg pentazocine every 4-6 hours
- 65 mg codeine every 4-6 hours
- 10 mg oxycodone every 4-6 hours

*Oxycodone may carry enhanced addiction potential

Situation 3 — *Severe Pain*

Aspirin/Acetaminophen *plus*
- 15 mg methadone
- 25 mg morphine
- 150-200 mg meperidine
- 120 mg codeine

**Remember*

1. Patients with acute severe pain (i.e., postsurgery, orthopedic procedures, obstetrical procedures etc.) should receive the medication *around* the clock for at least 24 hours. This avoids peaks and troughs in pain intensity and maintains sustained relief of pain.
2. These guidelines are to be applied to the *cancer* patient who may have pain of varying degree.

3. Meperidine should be administered every three hours. Schedules indicating administration every four to six hours are not appropriate.
4. Each patient requires careful dosage and dosage interval titration.
5. Exercise caution with methadone to avoid cumulative CNS depression, especially in the elderly and debilitated.
6. With continued therapy and tolerance development, dosage may need to be increased. Use caution but do not hesitate.
7. Aspirin should be substituted for acetaminophen in patients who have inflammation as part of their pain experience.

Chronic Pain

1. Non-tolerant patient: Use usual doses to start; excruciating pain or inadequate control may require a larger starting dose.
2. Attempt to reassess patient response periodically; proper dosage titration may eliminate the need to change medication.
3. Choose a dose that provides at least four hours of relief. No narcotic analgesic has a duration of action much longer than morphine. Remember, meperidine has the shortest duration of action.
4. Avoid the use of "prn — as needed" dosing schedules. If "prn" is selected, encourage the patient to ask for medication when the pain *begins* to bother him or her, not when the pain is most distressing.
5. Be aware of the oral-parenteral potency ratios when contemplating oral doses of the narcotic analgesics. Oral dosing is the preferred route of administration when possible.
6. Oral administration results in a slower onset, lower peak effect and more prolonged duration of action, desirable in the treatment of chronic pain.
7. Inject parenteral analgesics through existing intravenous lines when possible. Slow infusion (several minutes) is needed when the intramuscular doses are used. Avoid injecting the analgesics in the infusion containers.
8. Select alternative narcotic analgesics when the patient experiences adverse reactions.
9. Meperidine is less constipating and spasmogenic than morphine. Avoid concomitant administration of meperidine with mono-amine oxidase inhibitors. Repeated large doses may cause CNS excitation (convulsion).

Recommendations adapted from:
Moertel 1980
Beaver 1980
(see References)

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Emergency Thyroidectomy For Tracheal Obstruction

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Emergency thyroidectomy for severe spontaneous hemorrhage of a goiter has been reported in various publications. The purpose of this paper is to present a case of an enormous goiter with tracheomalacia necessitating an emergency thyroidectomy in order to establish an adequate airway. The highlights of the procedure, histological diagnosis and results are presented.

PROGRESSIVE thyroid enlargement can lead to obstruction of the airway and swallowing passages.[1] This is a case report of a patient who developed tracheal obstruction due to a long-standing goiter necessitating an emergency thyroidectomy and tracheoplastly as a life-saving measure.

Case Report

A 79-year-old white female patient had an enlarging goiter for many years. In recent months, she had progressive shortness of breath and difficulty swallowing. Pertinent findings revealed a well-developed, fairly well-nourished patient with marked acute respiratory distress. A markedly enlarged thyroid almost filled the entire neck and measured approximately 11 x 10 x 6 cm., compressing the trachea and pushing it toward the left (Figure 1). Severe inspiratory and expiratory stridor could be heard. Indirect laryngoscopy was attempted without success.

Included in the laboratory and x-ray findings was a plain x-ray of the neck which showed marked deviation of the cervical trachea to the left with compression at approximately the second and third tracheal rings (Figure 2). There was calcification within the mass lesion. Barium swallow revealed marked deviation of the cervical esophagus to the left (Figure 3). Electrocardiogram showed atrial fibrillation. The hemoglobin on admission was 14.1 gms.; hematocrit, 39.2 per cent. After completion of the above studies, the patient was taken to the operating room.

After induction with sodium pentothal and, with the use of fluothane (Halothane), the patient was intubated with a #6.5 endotracheal tube. The neck was then placed in hyperextended position, prepped with Betadine and draped in the usual manner. A transverse collar skin incision was made. A superior skin flap was elevated, subplatysmally. The deep cervical fascia was incised at the midline. The left strap muscles were retracted laterally to expose the less involved side. The left middle thyroid veins

Figure 1. Enormous goiter with tracheal obstruction after intubation at operating table.

2. Figure 2. Preoperative x-ray of the neck, A-P view, with marked deviation and compression of the trachea to the left.

were identified, clamped, cut and ligated. The left recurrent nerve was identified and preserved. The left lobe was then completely mobilized after transection of its suspensory ligament.

The dissection was then shifted to the right side of the neck. The midportion of the right strap muscles was transected. The right middle thyroid veins were found to be markedly enlarged and engorged. These were clamped, cut and ligated. Using sharp and blunt dissection, the immense mass was freed from its soft-tissue attachment. The right inferior thyroid artery was finally exposed; this was clamped, cut and ligated with 2-0 silk. The right recurrent nerve was identified and preserved. The entire mass was then removed from its tracheal attachment and from its suspensory ligament. The preceding technique was based on Lore's method of thyroidectomy.[2]

Sternothyroid Muscle Patch

On removal of the entire specimen, it was noted that the right anterior lateral wall of the first to the third tracheal rings had been softened and compressed. A sternothyroid muscle patch was used to cover the denuded tracheal rings.[3] A tracheostomy was then performed by removing an anterior segment of the fourth tracheal ring. A #6 tracheostomy tube (Shiley) was inserted into the tracheostomy opening, and the anesthetic agent was continued through this tube. The wound was irrigated with hydrogen peroxide solution and saline solution. Topical thrombin solution was instilled into the wound cavity. A Hemovac drain was inserted and brought out inferiorly through the skin. The right strap muscles were approximated. The skin incision was closed with skin clips in one layer, and a vertical skin incision was made at the midportion of the skin flap for the tracheostomy. A spray (Aeroplast) dressing was applied. The approximate blood loss was 600 cc.; consequently, a unit of packed cells was transfused. The patient tolerated the procedure well and left the operating table in satisfactory condition. Digoxin (Lanoxin) was administered by the internist for the atrial fibrillation.

The pathology report disclosed a 450-gram multinodular thyroid gland with acute infarction and an extensive hematoma measuring 8.5 x 8.5 x 7 cm. (Figure 4). The infarcted large thyroid nodule showed gross outlines of thyroid follicles with a thickened outer capsule. There was no carcinoma in this nodule. The noninfarcted adjacent thyroid tissue showed multiple smaller nodules, which were follicular carcinoma. Around the tumor nodules there was evidence of capsular and small-vessel invasion.

Figure 3. Preoperative barium swallow showing marked deviation of the esophagus to the left.

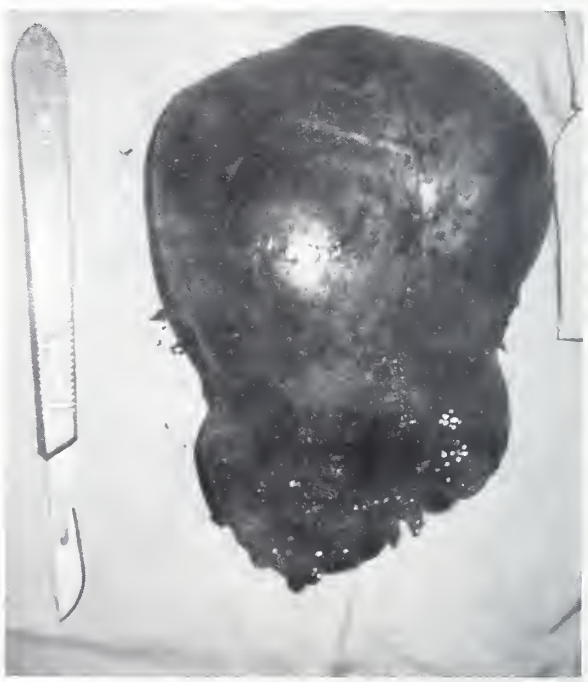

Figure 4. Goiter weighing 450 grams with associated follicular carcinoma.

Figure 5. Postoperative A-P x-ray of the neck with tracheostomy tube in place and an improved tracheal patency.

Hospital Course

The postoperative recovery of the patient was uneventful. She was fully alert and was swallowing well the day after the operation. She was placed on levothyroxine 0.2 mg. (Synthroid) daily, and was on digoxin 0.125 mg. (Lanoxin) daily. The calcium level dropped to 7.2 mg/DL on the seventh postoperative day; however, on discharge 12 days later, the calcium level was 8.6 mg/DL. A tracheal plug was inserted on the tenth postoperative day: this was tolerated by the patient. After decannulation she was discharged on the twelfth postoperative day. Postoperative barium swallow showed the restoration of the cervical esophagus and trachea to their normal positions. The tracheal lumen was adequately restored (Figure 5).

Discussion

Gradual enlargements of a goiter can lead to obstruction of the trachea or esophagus. In most cases of respiratory obstruction, symptoms are long-standing, and the degree of obstruction progresses very slowly so that patients can and do delay seeking medical help for a long period of time. Emergency thyroidectomy has been performed on spontaneous hemorrhage of a retrosternal goiter.[4] Sudden hemorrhage of a goiter, caused by injury, has been reported following attempts at strangulation during a family quarrel.[4]

Summary

A case of follicular carcinoma in an enormous goiter with severe tracheal and esophageal compression is presented. An emergency thyroidectomy with primary repair of the tracheomalacia using a muscle patch is described.

Editor's Note: Here are the generic drugs and trade names (in parentheses) to which reference is made in this manuscript: digoxin (Lanoxin), levothyroxine (Synthroid) and fluothane (Halothane)

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Medical Grand Rounds

From the West Virginia University Medical Center

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The Noninvasive Diagnosis Of Coronary Artery Disease

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When coronary angiography is not absolutely indicated, a noninvasive approach to the diagnosis of coronary artery disease is often desirable. However, because of the inherent imperfections of noninvasive testing, the results will always produce a relative uncertainty concerning the diagnosis, especially in patients with atypical symptoms.

This paper will discuss a format for approaching patients with suspected coronary artery disease by using noninvasive testing modalities. The discussion will emphasize the application of Bayesian analysis to both the interpretation of test results and the selection of the test or tests that will generate the most information in a cost-effective manner. Also included with this discussion will be comments on the criticisms and limitations as well as the future applications of the Bayesian approach.

All clinicians who are involved in evaluating patients suspected of having coronary artery disease (CAD) employ their skills of history-taking and physical examination as the initial step. Based upon these skills, we have all seen patients whom we thought had either a high or low probability of having CAD, e.g., a patient with typical angina pectoris with several strong risk factors. These clinical hunches would many times be put to the test by comparing them to the accepted "gold standard," in this case coronary angiography, and confirmation of our hunches would undoubtedly secure our faith in our clinical diagnostic abilities.

There often are patients, however, who defy categorization on clinical grounds and engender a relative uncertainty concerning their diagnosis, e.g., those with atypical symptoms. Diagnostic studies are not usually gratifying in these patients, and one's faith in certain clinical markers often is shaken considerably. Over the past 10-15 years, considerable effort has been put forth to explain the reason for these diagnostic pitfalls and to provide a practical noninvasive method for avoiding them. It is, therefore, the intent of this discussion to elaborate upon these two points in respect to the noninvasive approach to the diagnosis of CAD.

Noninvasive is an unfortunate adjective because several of the noninvasive tests are not strictly without penetration of the skin. Nevertheless, the term is uniformly understood by all to imply a test that is noncatheter or nonsurgical by nature, thereby carrying less risk, inconvenience and cost.

Coronary angiography, which is the current invasive standard for the comparison and evaluation of these noninvasive studies, is a useful clinical tool, but is by no means perfect, as has been pointed out by Roberts *et al.*[1] It is only the angiographic delineation of coronary luminal anatomy with often little to say about the effect of that anatomy on the perfusion to the myocardium downstream. In considering the fact that most, but not all, of the noninvasive studies investigate a physiologic aspect of the

coronary system, it is not a surprising fact that noninvasive studies will be less than perfect in predicting the coronary, i.e., luminal, anatomy. It is the classic case of comparing apples and oranges, which are obviously quite different, but both classified as fruit. Luminal anatomy and ischemia are both expressions of coronary atherosclerosis, but they are entirely different categories of expression.

Add to this the fact that the hallmark for the diagnosis of CAD is usually a qualitative assessment, and the problems of comparison are magnified further. The percentage of reduction in the cross-sectional area of the coronary artery that leads to a measurable physiologic change is reasonably well defined, but the ability to measure visually that percentage of reduction is far from perfect. Granted, an apparent lesion of greater than 70 per cent, more often than not, will be physiologically significant, but what about the lesions that "look like" 40-60 per cent? Also, positive noninvasive study results may be indicating other types of heart disease that are not seen by the angiogram. Clearly, the "gold standard" needs improvement.

The list of noninvasive testing currently or soon to be available is noted in the Table. All, with the exception of fluoroscopy, examine the effects of ischemia on some aspect of coronary or ventricular physiology. These aspects also are noted in the Table. Indeed, it is not my intent to discuss the relative advantages of each modality, but rather to provide a format for interpreting the results of these tests and assessing their utility in the light of their well-documented imperfections.

Predictive Accuracy

Before discussing the format for analysis, I would like to present some background information. First, the accuracy of diagnostic tests is usually indicated by the terms, sensitivity and specificity.[2] These terms define the ability to detect patients with and without disease, respectively. These quantities say nothing as to the probability of disease in an individual. That particular quantity known as predictive accuracy (PA) or value, therefore, comments on the test result rather than the test itself. It is a quantitative expression of the likelihood that a given test result indicates the presence of disease. In general, it is a much more clinically useful value than sensitivity or specificity.

These three values are all dependent upon how a positive or negative test result is defined and, as expected, the measured values will be different for each test result. Herein lies the fallacy of the conventional, but oversimplified, classification of test results as either positive or negative. Rifkin and Hood demonstrated that for exercise stress testing there is a continuum of risk depending upon the absolute amount of ST segment depression.[3] Virtually all of the nine basic tests available have either a wide range of tests results (as for exercise ECG) or 3-4 discrete test results (as for exercise radionuclide angiography). Therefore, these multiple possible test results, rather than providing a definitive answer as to the presence or absence of CAD, provide a probability statement concerning the likelihood of disease.

Effect of Disease Prevalence

Second, a number of studies have shown that the PA of a test result is dependent upon the chance of the patient having CAD before the test is administered.[3-5] This pretest risk also is known as prevalence or pretest likelihood, and is the main ingredient in the format called "conditional probability analysis," which will be discussed shortly. Referring to large groups, the prevalence represents the percentage of the population that is affected by CAD at any given time. This principle of dependence of PA on

TABLE

Noninvasive Testing Modalities and Aspects of Cardiac Anatomy and/or Physiology Examined

1.	Exercise Electrocardiography°	Electrical Repolarization
2.	Exercise Thallium Scintigraphy°	Perfusion
3.	Exercise Radionuclide Angiography°	Myocardial Function
4.	Exercise Cardiokymography	Myocardial Function
5.	Exercise Echocardiography	Myocardial Function
6.	Coronary Fluoroscopy°	Calcification of Arteries
7.	Positron Emission Tomography	Myocardial Function, Perfusion, Metabolism
8.	Nuclear Magnetic Resonance	Myocardial Function, Perfusion, Metabolism
9.	CAT Scanning	Myocardial Function, Perfusion
10.	Digital Subtraction Technique	Myocardial Function

°*Most-available tests with the best data to generate PAs.*

prevalence or pretest likelihood is more familiarly known as Bayes' Theorem. There has been much discussion of this theorem in the medical literature over the last 20 years, and its mention is increasing exponentially.[6-8]

The prevalence for CAD has been determined for several clinical classifications from pooled autopsies according to age, sex and chest-pain symptomatology.[9] Diamond and Forrester[10] also have developed a computer program for determining prevalence considering these variables as well as coronary risk factors. This same group also has shown that the prevalence of disease for asymptomatic patients (which is much lower than for symptomatic patients) can be approximated from the Framingham study data presented in the Coronary Risk Handbook.[9]

In addition to Bayes' Theorem, there also is a formula bearing that name which allows for the calculation of PA given the prevalence or pretest risks and the sensitivity and specificity for each test result.[7] Unfortunately, all of the tests have not been investigated sufficiently to establish sensitivity and specificity data, but Forrester *et al.* have presented the sensitivity and specificity results for pooled studies for five noninvasive tests with data on virtually all of the possible normal and abnormal results for each of these tests.[9,11]

Conditional Probability Analysis

With sensitivity, specificity and prevalence in hand, one next can begin to address the question of interpreting test results. This process is termed "conditional probability analysis" because the originally-believed probability is modified by the conditions of an observation, in this case, a test result. Clinicians intuitively employ probability analysis in making diagnostic decisions, but, as noted earlier, not without noticeable imperfection or uncertainty.

Bayes' formula allows us to take a test's sensitivity and specificity and the patient's pretest likelihood for CAD, and calculate a post-test likelihood or PA for disease. If we take a spectrum of prevalence ranging from 0-100 per cent and determine the PA for each point, we can generate a series of PAs which will form a curve with a parabolic configuration.[9] Using these curves, the PA for a test result can be determined by simply knowing the pretest risk or prevalence. These curves, as well as tabular data, can be seen in a number of excellent review articles on this subject.[2,9,12,13] Data for exercise electrocardiography, thallium exercise testing, exercise radionuclide angiography, and coronary cinefluoroscopy, which make the determination of PA or post-test likelihood very easy,[11] recently have been published. In addition, there is a computer software program available which will determine the PA for five noninvasive tests.[10]

Two Interpretations

Now assuming one takes the time to determine the likelihood of disease before or after a test, what then does one do with this value? Clinically speaking, there are two ways of interpreting the probability. The first deals with the likelihood of disease in the patient based upon an achieved test result. This is a diagnostic interpretation.[9] Concerning this interpretation of the PA, Diamond *et al.*[14] have suggested from the techniques of information theory that a PA of less than 10 per cent or greater than 90 per cent should be the diagnostic end points for noninvasive testing. In other words, if a patient's PA is in those ranges, further noninvasive testing for diagnostic purposes is not warranted except in very special circumstances.

These diagnostic end points have not been completely validated yet but, clearly, further noninvasive studies will only serve either to confirm what is already strongly supported by the evaluation to that point, or cloud the picture considerably by moving the PA between 10 and 90 per cent. Ideally, of course, a physician should select a threshold above which one action will be taken and below which another action will be taken, e.g., consider having CAD and treat appropriately or doing another diagnostic test.

The second type of interpretation deals with predicting the discriminative function of a test yet to be performed.[12] The major difference between the two interpretations rests upon whether the likelihood is determined before or after the test is performed. Although it is possible to render an interpretation of an achieved test result by finding the PA for that result, it also is possible to see what the PA will be if the patient generates a proposed result.[14] For example, given a prevalence of 50 per cent in a particular patient, one can determine whether a negative exercise electrocardiographic result can, for practical purposes, exclude CAD, i.e., reduce the likelihood to a very small number. While in many instances this will be helpful, the real impact of this type of interpretation will be felt when one is considering the more expensive noninvasive studies such as thallium scintigraphy.[15] The important principle here is avoidance of unnecessary or insufficiently discriminative testing. If coronary angiography were a quick and inexpensive test with no risks, there would be less justification for noninvasive

studies. However, since this is not so, avoidance of the cost and risk of angiography is a major driving force behind noninvasive testing. But if we have utilized a number of expensive noninvasive studies arbitrarily, we already may have negated one of the advantages of noninvasive testing. Therefore, the take-home message is the following: let us try to avoid coronary angiography if we can, but not at the expense of spending more to avoid the angiogram than it would have cost to perform it.

Practical Examples

Currently, only four or five of the noninvasive studies in the Table have been evaluated to the extent that tables for PA determinations are available.[9,11] It should not be our intent to use all of the testing modalities in a patient, but to select the one or two which will yield the most information in a cost-effective manner.[15] I believe the Bayesian format attempts to provide this cost-effective selection process. Although far from its final form, it is practical in its present state and, from studies done thus far, it would appear that the major use of single or multiple noninvasive studies is for the assessment of the group of patients with a prevalence for CAD between 10 and 90 per cent.[12,14]

Further subdivision of this large group leads to branching logic trees that are far more confusing than clarifying. Let me instead present some practical examples to demonstrate the usefulness of this format:

1. A 55-year-old man with typical angina pectoris had a prevalence of 92 per cent. An exercise stress test will be performed and, if the test is positive, the increase in diagnostic accuracy will be marginal (four to 96 per cent) and will confirm what already was evident from the history. If the test is negative, the PA will be 73 per cent. Therefore, CAD certainly will not be excluded. Therefore, the exercise test will not really be useful diagnostically, although it may be useful for other purposes. Furthermore, it is not likely that subsequent noninvasive testing will help to exclude CAD with enough certainty to warrant its expense. This is simply because of the fact that in this case no noninvasive study will lower the PA enough to say that angiography is not needed to exclude the diagnosis.

2. If the same man had atypical angina, his prevalence would fall to 59 per cent, and the negative stress test would yield a PA of 25 per cent. What you do at this point depends on your philosophy of practice, but what is important to understand is that there is still a one-in-four chance of CAD. One further noninvasive study (Thallium) would be very discriminative. If negative, the PA will be six per cent; if positive, 79 per cent. This would be enough discrimination to make a reasonable decision. In general, the probability information, although not definitive, will be sufficient to justify a management decision. Of course, if absolute certainty is desired, coronary angiography is the only recourse.

3. Let us suppose a 45-year-old woman presents with atypical angina yielding a prevalence of 13 per cent, and her stress test yielding one and one half mm of horizontal ST segment depression, raises her PA to 39 per cent. A negative Thallium scan would lower it to 10 per cent whereas a negative radionuclide angiogram would lower it to two per cent. If one had obtained coronary fluoroscopy after the stress testing and obtained a negative result, Thallium would then lower the PA to 5 per cent.

4. One final example is a 45-year-old asymptomatic man who desires an exercise test before starting an exercise program. Without considering risk factors, his prevalence is six per cent. By using the Coronary Risk Handbook,[16] one could modify his pretest likelihood up or down to, for example, 10 per cent. He then exercises, producing two mm of ST segment depression yielding a PA of 52 per cent. How one handles him once again depends on one's philosophy of practice, but a negative radionuclide angiogram would lower the PA to four per cent, and a negative Thallium study would lower it only to 16 per cent. It should be clear to the reader that if one waits until after the test is performed to determine the PAs, one may find that the effort and expense were wasted. Therefore, one can evaluate whether a single or a series of noninvasive studies will be useful by looking at the extremes of possible test results. I should note that the order of test sequencing does not influence the final likelihood. This would allow one to modify considerably and individualize a diagnostic approach.

Test Limitations

Thus far, I have touted the merits of this approach but, to be fair, I should mention and comment upon the criticism it has received and its limitations. In this respect, Feinstein has been the most outspoken, considering the application of Bayes' Theorem to clinical medicine.[17] His objections have been theoretical, for the most part, and while it is true that not all areas of medicine are appropriate for this type of

analysis, the real merit of any diagnostic approach ultimately should be based upon its success and not its theoretical limitations.

Statistical independence of test results means that the results of different tests are based on end points that are independent of one another. For example, two tests should not be both looking at the same parameter such as ventricular function. Since Bayes' Theorem requires adherence to this principle, serial application of tests that are not independent could invalidate the results. However, it has been demonstrated that the influence of this principle is not significant as long as the number of tests sequentially employed is small.[18] This is true for the approach presented here. Likewise, it would appear that the most easily available tests (starred in the Table) are independent as the endpoints are all different (repolarization, perfusion, ventricular function, and artery calcification).[19]

Feinstein has stated that this decision process does not even closely resemble the real clinical situation because of the complexity of the usual situation and the subjective nature of the data.[17] Also, because of the continued vagueness of the PA, he states that clinicians usually order the most suitable tests to rule in or rule out disease. He states that if there is uncertainty, one should get more data. What he fails to realize is that in clinical medicine the most cost-effective test should be ordered, and not always the most suitable one, i.e., coronary angiography. However, with so many noninvasive tests available, the practicing physician is often at odds with selecting the most cost-effective study for the individual patient.

Bayesian Analysis Could Help

Clearly, a procedure's cost-effectiveness is greatly dependent upon how often it is appropriately ordered.[15] Even highly sensitive and specific tests may not lead to cost savings if they are ordered inappropriately for patients who will not experience a change in management resulting from the test. Procedures with greater risks and inconvenience such as coronary angiography are more likely to be appropriately ordered than are noninvasive studies. This inappropriate ordering only serves to promote overutilization of the study which, in turn, tends to reduce its cost-effectiveness. This principle was demonstrated in a study by Feinstein himself.[20] Therefore, Bayesian analysis could be just the method for improving cost-effectiveness by using the uncertainty inherent in all of these studies to our best advantage.

Next, Feinstein stated in 1977 that he knew of no published work that demonstrated the successful application of Bayes' method to clinical medicine.[17] This was a valid criticism then, and I would certainly agree that any new diagnostic method needs to be compared to the current standards to see if diagnostic accuracy, patient care and cost-effectiveness are really improved.

Since 1977, several papers comparing the clinical to the calculated likelihood of disease have been published.[9,14,21,22] Hlatky *et al.*[22] have published data indicating that probability calculations considering only age, sex, chest pain, and exercise EGG response were at least as good as the cardiologists' assessment and, in a few instances, better. These probability calculations were improved upon when a computer program involving more variables was involved.[10,22] Indeed, there is a lot to be learned concerning these techniques, but to say that their accuracy is unproved is no longer true. In all fairness, I have not seen any comment by Feinstein concerning these subsequent studies. The ultimate test will be to assess their cost-effectiveness in some sort of randomized, prospective clinical trial.

Pooled versus Local Data

One area of difficulty that is not easy to deal with is the universally assumed values for sensitivity, specificity and prevalence. The sensitivity and specificity data quoted in the literature [9,11] are derived from pooled data from many sources and may not be the values that practitioners are working with in their local institutions. If the determination of the local sensitivity and specificity is possible, this should be done, but where this cannot be done, the published values should be utilized as the best and only available figures. Also, prevalence can vary from area to area with the published figures representing only a pooled average.[9] Obviously, the validation of the pooled prevalence data in a number of geographical regions would help to weaken this criticism.

In addition to the presence or absence of disease, noninvasive tests are also ordered, often simultaneously, to obtain other information, e.g., location and severity of disease. Thus far, standard Bayesian analysis does not consider these other questions, but once again, Diamond *et al.* have demonstrated a computer-assisted approach which does address this important question.[10] Further applications to these questions should be forthcoming.

The exercise test long has been maligned for its excessively high false negative rate.[23] Mostly, this is due to the naive consideration of only ST segment depression in the test result. When a multivariate approach is used. much better accuracy is obtained.[24] Santinga *et al.* also have incorporated other stress test variables into their Bayesian analysis.[25] Validation of these refinements as well as others that use a multivariate approach certainly will be necessary in order to maximize the diagnostic capability of each test.

Unfortunately, as long as coronary angiography is the "gold standard," one limitation will always be present. For those who prefer a yes or no answer, noninvasive testing virtually will never be satisfactory. If one cannot deal with uncertainty, as some have made clear, then this type of analysis will be only an academic exercise with no real clinical application. On the other hand, one also should not be misled into thinking that this analysis is a panacea that will make gray-area decisions black or white. It is intended as a clinical tool or guide to complement the other clinical skills and tools, and assist in selecting and interpreting a test or tests so that the patient will be presented with the least amount of uncertainty concerning a diagnosis.

The appearance of Bayes' Theorem in the literature is likely to increase as long as there are those who are comfortable with probabilities in place of discrete yes or no answers. As to its true cost-effectiveness, I look forward to studies addressing this very important question.

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A message from . . .

The President

ETHICS, MEDICINE AND SOCIETY

IN all the hubbub, clamor and furor of the current debate about "cost containment," one other concept of significance seems to be emerging and quite possibly changing. This is the broad concept called ethics. We are all aware of the impact of ethical considerations in our lives, but these generally have been somewhat esoteric, and have not received widespread publicity or public attention. Increasing demand for unlimited, high-quality medical care in the face of finite resources may force us all to re-examine our beliefs about these difficult concepts which eventually will confront us all, physicians or laymen alike.

Of course, physicians, since the dawn of time, have been subjected to different creeds of ethics developed for the benefit of the patient, from the Oath of Hippocrates down through the American Medical Association's Principles of Medical Ethics. Physicians are not unfamiliar with the problems involved in making the choices and decisions required in the care of our patients, but these choices and decisions now apparently are spreading to involve a broader segment of society. Ethical dilemmas such as appropriate care of an incompetent patient, possible rationing of medical care due to increasing demand and decreasing resources, or the advisability of withholding treatment in hopeless situations, increasingly are becoming more prominent and publicized. These ethical and moral decisions have been made by physicians from time immemorial but there seems to be a growing trend to extend this responsibility.

The question, it seems to me, is becoming who has the responsibility or obligation to make these decisions? In a recent study from California, it was estimated that approximately 20 per cent of the resources of a group of hospitals was expended to care for people whose prognosis was less than a year. In the Medicare program, around .5 per cent of the patients, those with end-stage renal disease, consume almost 10 per cent of the funds. Is it ethical to expend so much of society's resources on a limited number of people or on those with very little chance of long-term survival? If so, why? And, if not, who is to make that decision? Is it ethical to deny expensive and potentially painful care to a baby born with severe birth defects, or is it more ethical to expend all of our energy, resources, and technology to prolong this life? Do we place a value in dollars and cents on an individual life? And, if so, who determines that value? Do ethical considerations come down in the end to a matter of money? If society as a whole pays the bill, who has the right to dictate to an individual what his or her choices must be?

These are indeed difficult questions. And for me, at least, the answers are not clear. In the practice of Medicine, however, in this day and age, there seems to be a requirement for answers to these possibly unanswerable questions. How do we approach this? Is it the duty of our elected officials to provide answers to these questions? If so, has the Legislature understood and accepted this awesome responsibility? Or, is it the province of the courts to make these determinations? Will our already overburdened legal system be able to respond to the split-second decisions that are sometimes required? Is it able to accept this responsibility in a timely fashion?

These are but a few of the many questions that arise when ethical considerations meet harsh economic realities. Attempting to answer these questions will challenge us to re-evaluate our own beliefs and behavior as well as those of others. I feel it is the responsibility of our profession, as on so many other occasions, again to take the lead in evaluating these questions and trying to resolve them. If we do not, we can rest assured others will.

Harry Shannon MD

HARRY SHANNON, M. D., *President*
West Virginia State Medical Association

The West Virginia Medical Journal

Editorials

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author shall be held entirely responsible. Editorials printed in The Journal do not necessarily reflect the official position of the West Virginia State Medical Association.

PUBLIC RELATIONS

One can still hear around Medical Society meetings comments to the effect, "What the profession needs is some good public relations. The public just doesn't know enough about what goes on in Medicine to appreciate what they've got . . ."

Perhaps this was once true. But in recent years we've been getting publicity, lots of it. It's hard to pick up a newspaper these days without finding prominently displayed some story depicting medical technological wizardry being applied to some unfortunate victim of disease or accident. Medical columns by physician journalists are rampant. News services scan scientific journals and frequently announce scientific advances before the mailman delivers the journals. No news magazine worthy of the name is without its *Medicine* section. Television networks have full-time medical experts appearing in popular time spots discussing common or rare afflictions and giving advice. Publishing houses solicit manuscripts and print books on diets, exercise programs and a host of medical fads.

One might be led to think now that, rather than being medically uneducated, the public knows too much. And knowing too much, they expect too much. "Why shouldn't my father (husband, son, mother, wife, cousin . . .) have an artificial heart like that dentist?" Or, more likely, "If they can put an artificial heart in that dentist and keep him alive, why did my father (husband, son, mother, wife, cousin . . .) die of a little thing like a ruptured ulcer (ruptured spleen, ruptured aorta, pulmonary embolus . . .)?"

The increased medical sophistication of the public has not led to increased respect and appreciation for doctors. PDR's are a big seller; patients now want to quiz the doctor on his knowledge of drug side effects and incompatibilities, and, frequently enough, to negotiate on which might be the drug of choice to treat their condition.

Good public relations were supposed to make life better for the doctor and patients easier to deal with. Sadly, that has not happened. Patients are now informed and doctors now struggle to get informed consent. Patients are smarter and less trusting. Patients and doctors alike now have personal attorneys. Where a family once had a bottle of Mercurochrome and a tin of aspirin in its medicine cabinet as its bow to medical preparedness, they now have a sphygmomanometer.

There wasn't really too much that was good back in the good old days of Medicine but a medically unsophisticated patient was surely a pleasure. There are certainly others about in need of good public relations . . . if we could only tout the reporters onto them somehow, maybe . . .

DRGs

It's not a mnemonic. It is hardly even an attractive group of initials, suggesting at best, perhaps not inappropriately, a dirge. But if HCFA, a not very attractive group of letters either standing for Health Care Financing Administration of the Department of Health and Human Services, has its way, these will soon be as well known to physicians as IRS or FTC.

Diagnosis Related Groups. Practically all of Medicine is wrapped up into 467 of them. An industrial engineer with a special knowledge of industrial quality control accomplished this remarkable task of distillation. A medical product has been described; the production process defined; and a cost control method created.

The system developed is to be applied to hospitalized patients paid for by Medicare. Other third-party payors have shown a keen interest in employing the same or a similar program for their subscribers. Presently, it is to apply only to hospital charges, not to physician fees.

Although the payment mechanism has been described as *prospective*, the actual payment is

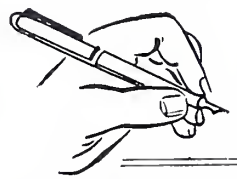
based on a discharge diagnosis for each covered individual. The discharge diagnoses are what constitute the DRGs. They are complex and arborized along the lines of an algorithm: the first division is surgical-nonsurgical; the next, complications; then concomitant conditions; age; discharge status; etc., etc., etc.

The final elaborated diagnostic form festooned with all pertinent problems and procedural information is matched with one of the 467 DRGs, each of which carries with it a set dollar figure tailored to the particular geographical area and type of hospital.

One set price, no matter the LOS, time in ICU, number of C-Ts, EEGs, the size of the stack of x-rays or sheath of laboratory studies. Hospital administrators are worried. The staff could break them. Schemes to marry the clinical and administrative functions of hospital care are proliferating.

It's a time for innovation. It is a time for medical staff to be on their collective toes and to enter into the process of shaping whatever change is required.

Some form of a hospital payment system using DRGs seems imminent. If physicians are to ignore the clear handwriting on the wall on this issue, DRGs could spell DOA to the amicable medical staff-hospital relations such as we presently enjoy.



Our Readers Speak

Unusual Case In State

Rocky Mountain Spotted Fever (RMSF) is an uncommon disease in West Virginia, with only eight reported cases in 1982.[1] It is diagnosed more often in the bordering states of Maryland and Virginia, with 50 and 73 cases, respectively, last year.[1] Peak incidence is in the spring and summer months when both ticks and humans are active in the outdoors.[2] So, we were surprised to find a January RMSF case in central West Virginia.

A 14-year-old white male, a resident of West Milford in Harrison County, presented to the Emergency Department of United Hospital Center in Clarksburg on January 15, 1983. He complained of an eight-day illness which started with intermittent fever to 102°F, headache, and myalgia. He had been seen in the office on the third day of the illness, at which time he appeared mildly ill, and had a temperature of 102°F, but otherwise had a normal examination. He was sent home on symptomatic treatment for a presumed viral illness.

A throat culture was taken and was negative for *Streptococcus*. His symptoms worsened and his evening temperature spikes reached 104°F. On the sixth day of the illness, a macular, mildly pruritic rash appeared on his hands and feet and spread inwards. He also developed a mild sore throat and had increased myalgia in his legs.

He denied any history of tick bite, although the family does have two dogs. He had hunted and helped his brother with trapping this winter, and had limited contact with killed rabbit and other animals. The family lives in an old house and has a problem with rats. He had no known contact with contaminated water or foodstuffs, had not traveled recently, and had never been outside the northeastern United States. No one else in the family was ill. The only medication was acetaminophen (Tylenol); he has no known drug allergies.

On admission, the temperature was 103.8°F; pulse, 88, and respiration, 20. He appeared moderately ill. Examination showed muscle tenderness on palpation of the lower extremities, and two rashes: one, a fine, petechial, hemorrhagic rash most prominent on his lower legs, ankles, and soles; the other, an erythematous, macular, papular rash on his extremities, face and trunk, which disappeared during the course of the examination. The examination was otherwise unremarkable.

Admission hemogram showed a white count of 6,600 with 33 stabs, 23 polys and 44 lymphs; hemoglobin, 13.0 gm; MCV, 86.1, and platelet count, 119,000. Westergren ESM was 6 mm/hr. Urinalysis was normal. Mono spot was negative. RPR was non-reactive. Febrile agglutinins drawn on admission were positive for *Proteus* OX2 at a titer of 1:80 and *Proteus* OX19 at a titer of 1:40; *Proteus* OXK, Typhoid H, Typhoid O, *Brucella*, and *Pasturella tularensis* were negative. Cold agglutinins were positive at a titer of 1:8; acute *Mycoplasma* and *Leptospira* titers were negative. Blood cultures and repeat throat culture showed no growth. ASTO titers were negative. Chemical profile showed alkaline phosphatase elevated at 245 IU/L, LDH elevated at greater than 600 IU/L, and SGOT elevated at 168 IU/L. Chest x-ray and EKG were normal.

The patient was treated with doxycycline (Vibramycin) 200 mg. po stat, then 100 mg. po b.i.d. He also received acetaminophen for fever and hydroxazine HCL (Atarax) for itching. At no time did he appear more than moderately ill. The petechial rash persisted but did not worsen. The platelet count dropped to 89,000 on the second hospital day, then rose. He had several more transient episodes of a macular, papular rash which at times had a sandpaper-like texture, and also had episodes of transient, pruritic, urticarial rash. He continued to have evening temperature spikes which gradually decreased, and became afebrile on the fourth day of treatment. He was discharged home on doxycycline 100 mg. po daily to finish a 10-day course.

He was seen in the office one week later, at which time he felt entirely well. Convalescent titers were obtained two weeks after the acute titers had been drawn. Convalescent *Proteus* OX2 was positive at a titer of 1:320, showing a four-fold rise; *Proteus* OX19 was 1:320, showing an eight-fold rise. Other febrile agglutinins again were negative, as was repeat mono spot and *Mycoplasma* titers, *Leptospira* titers, and a hepatitis screen.

Comment

This patient had a fairly typical presentation for RMSF, except that the illness was milder than expected from textbook descriptions, and that a tick-borne zoonosis is unexpected in January in West Virginia. The serology is typical for RMSF; murine (endemic) typhus also could give these results, but we feel the nature of the rash confirms the diagnosis of RMSF.

We assume the unusually warm winter has allowed continued risk of tick exposure. Also of note for central West Virginia physicians is the focal nature of RMSF cases, with limited geographic areas accounting for a high percentage of cases in a given state.[2]

1. MMWR 31:52, 705 01/07/83
2. Scientific American Medicine 7: XI :1

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GENERAL NEWS

VD, Gay Patient Diseases Convention Subjects

Venereal diseases and diseases of the gay patient will be discussed by physicians from Marshall University and the University of Pittsburgh during the State Medical Association's 116th Annual Meeting.

Lee P. Van Voris, M. D.

George J. Pazin, M. D.

The two papers will be part of a "Symposium on Sexually Transmitted Diseases" constituting the initial general scientific session on Friday morning, August 26.

The convention will be held August 25-27 at the Greenbrier in White Sulphur Springs.

Dr. Lee P. Van Voris, MU Associate Professor of Medicine, will speak on "Non-Luetic, Non-Gonococcal Venereal Diseases," and Dr. George J. Pazin, Associate Professor of Medicine at the University of Pittsburgh, will discuss "Transmissible Diseases of the Gay Patient," the Program Committee announced.

Other individual topics for the Friday morning session will be syphillis and gonococcal infections, and sexual mores in the 1980s. The session will follow traditional opening exercises; the keynote speaker for the latter program will be announced later.

The Annual Meeting will open with a pre-convention session of the Association's Council and the first session of the House of Delegates on Thursday morning and afternoon; and end with the second and final House session and reception for new Association officers on Saturday afternoon and evening.

Doctor Van Voris, effective in May, will leave MU to become Chief of Infectious Diseases and Hospital Epidemiologist at Hamot Hospital in Erie, Pennsylvania. He will have the continuing appointment, however, as MU Clinical Associate Professor of Medicine. He has been on the MU faculty since 1978.

Doctor Van Voris was graduated from Kenyon College in Gambier, Ohio; received his M. D. degree in 1971 from State University of New York (SUNY) Upstate Medical Center, Syracuse; interned at Los Angeles County Harbor General Hospital in Torrance, California; and completed residencies at that hospital and at SUNY Medical Center, Syracuse. He received a fellowship in infectious diseases from 1976 to 1978 at the University of Rochester (New York).

Certified in internal medicine, Doctor Van Voris is a Fellow of the American College of Physicians, and a member of the Board of Directors, West Virginia Chapter, Association for Practitioners in Infection Control.

He is the author or co-author of four books and or book chapters, 10 abstracts, and 18 scientific articles.

'Pitt' Graduate

Doctor Pazin is a graduate of the University of Pittsburgh School of Medicine and the University's Health Center Hospitals program in internal medicine. During an academic fellowship in infectious diseases under Dr. A. I. Braude, he also earned a M. S. degree in microbiology.

Doctor Pazin served two years in the Venereal Disease Branch of the U. S. Public Health Service at the Centers for Disease Control in Atlanta, Georgia, and completed his infectious disease fellowship at the University of California, San Diego, before returning to the University of Pittsburgh. Board certified in internal medicine and infectious diseases, he has published in a wide range of areas from interferon and herpes viruses to aminoglycoside pharmacokinetics in obesity; office bacteriology; candidiasis; endocarditis; gonorrhea, and "Pittsburgh pneumonia agent."

His main research efforts during the past five years have involved investigations of the clinical applications of human leukocyte interferon in relation to: (1) reactivation of herpes simplex virus following neurosurgery, (2) treatment of extensive skin papillomas (warts) in a patient with atopic eczema, and (3) treatment of genital herpes in women.

The second general scientific session will be held Saturday morning, August 27 and, as announced previously, will be a symposium on cardiovascular diseases. The Saturday morning topics will include new developments in the management of cardiac arrhythmias; an update relative to cardiovascular surgery, and the management of congestive heart failure.

Special Groups

In addition to the general sessions, the Annual Meeting agenda will include breakfast, luncheon and other programs arranged by specialty societies and sections, many of which also will provide scientific discussions.

The specialty group meetings will be held in large measure on Friday, with a few to be set for Saturday morning, preceding the second general sesion, and at noon.

At the final House session on Saturday afternoon, Carl R. Adkins, M. D., of Oak Hill will be installed as the Association's 1983-84 President to succeed Harry Shannon, M. D., of Parkersburg.

The Auxiliary to the State Medical Association, with Mrs. Richard S. Kerr of Morgantown the current President, as usual will hold its meeting in conjunction with that of the Association.

Putting their heads together during the recent 16th Mid-Winter Clinical Conference in Charleston are, from left, Drs. Harry Shannon of Parkersburg, President of the State Medical Association; Jack Leckie, Huntington; and David Z. Morgan, Morgantown. The annual continuing education program is sponsored by the Association and the West Virginia University and Marshall University Schools of Medicine.

Members of the 1983 Program Committee are David Z. Morgan, M. D., Morgantown, Chairman; Doctor Adkins; Jean P. Cavender, M. D., Charleston; Michael J. Lewis, M. D., St. Marys; Kenneth Scher, M. D., Huntington, and Roland J. Weisser, Jr., M. D., Morgantown.

Additional information concerning speakers and other convention details will be provided in upcoming issues of *The Journal.*

Legislature Enacts Hospital, Nurse, Therapist Measures

Bills establishing a hospital cost containment authority, and easing registered nurses—regardless of levels of training—and physicial therapists into independent practice sailed through the recent legislative session during its final hours.

Failing to pass were bills to extend from 1984 to 1987 temporary permit mechanisms for unlicensed physicians, and require parental notification prior to the performing of an abortion on a minor.

The controversial nurses legislation will require, as of January 1, 1984, third-party reimbursement for non-salaried primary health care nursing services and can cause substantial problems for the insurance industry and others.

The West Virginia Nurses Association has emphasized in its publication that its goal has been recognition of the independent practice of nursing, and to provide "the citizens of West Virginia with the freedom to choose between various health care providers."

Referrals No Longer Required

The physical therapist bill will permit those licensed individuals to treat persons other than those referred by physicians, dentists or podiatrists, as the law has required.

The bill, heavily lobbied by freshman Delegate Joe Manchin III (D-Marion), was passed finally by the Senate, 26-4, just two minutes before the end of the regular session at midnight on Saturday, March 12.

The final Senate vote, held up for several days, followed Manchin's eventual support of a largely Senate version of the hospital cost containment bill, passed in the Senate 21-13 and in the House 63-34 after adoption of a conference committee report.

As this copy was written on *The Journal* deadline for the April issue, more detail on the hos-

pital and other legislation will be developed later. The Legislature provided for a three-member rate-review and rate-setting authority to be established within the West Virginia Department of Health structure (see story on page 91).

Other bills enacted by the Legislature, if approved by the Governor, will:

—Set up a procedure for patients, upon written request, to obtain from health care providers copies or summaries of their medical records—with safeguard covering doctors' notes, psychiatric situations and others (legislation prepared and strongly supported by the State Medical Association).

—Require that at least 40 per cent of hospital boards of directors be representatives of small business, organized labor, the elderly and persons with income less than the national median.

—Permit certain authorized personnel to provide corneas to the state medical eye bank pursuant to an autopsy (supported by the State Medical Association).

—Eliminate chest x-rays for school personnel and children unless medically indicated.

—Provide for licensure by the West Virginia Department of Health of birthing centers: and authorize use of certain state funds for payment of birthing center services.

—List specific birth defects to be reported to the West Virginia Department of Health in further implementation of a 1982 act supported by the State Medical Association.

—Revise and tighten educational and other requirements for Type B physician assistants.

—Provide that investigators appointed by the West Virginia Board of Pharmacy need not be registered pharmacists.

—Update the list of controlled substances in line with West Virginia Board of Pharmacy recommendations.

—Re-establish a 10-member Workers' Compensation Fund Advisory Board, with three members representing providers of medical services to employees for which such providers are compensated by the fund (supported by the Sate Medical Association).

—Permit the State Health Director to make emergency payments for certain health care services.

—Rename the Department of Welfare the Department of Human Services.

—Rename the Workmen's Compensation Fund the Workers' Compensation Fund.

Continuing Education Activities

Here are the continuing medical education activities listed primarily by the West Virginia University School of Medicine for part of 1983, as compiled by Dr. Robert L. Smith, Assistant Dean for Continuing Education, and J. Zeb Wright, Ph. D., Coordinator, Continuing Education, Department of Community Medicine, Charleston Division. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of The Journal.)

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the Morgantown, Charleston and Wheeling campuses. Further information about these may be obtained from: Division of Continuing Education, WVU Medical Center, 3110 MacCorkle Avenue, S. E., Charleston 25304; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 2000 Eoff Street, Wheeling 26003.

April 12, Summersville, Child Abuse & Neglect, Part I (Sponsor, WVU Charleston Division)

April 15, Charleston, Aspiration Biopsy Cytology

April 15-16, Morgantown, Cancer Teaching Days

April 19, Summersville, Child Abuse & Neglect Part II (Sponsor, WVU Charleston Division)

April 21-22, Morgantown, Workshop for Infection Control Practitioners

April 28, Wheeling, Balance Disorders

April 29, Charleston, Research Day

April 29-30, Morgantown, Orthopedic Reunion Days

May 7, Charleston, Outpatient Infectious Diseases

May 20-21, Morgantown, Health Officers Conference

June 3-4, Morgantown, Anesthesia Update '83

June 4, Charleston, 10th Annual Wildwater Conference — Medical & Surgical Update

June 11, Morgantown, Interventional Radiology

(continued on next page)

Regularly Scheduled Continuing Education Outreach Programs from WVU Medical Center/ Charleston Division

Buckhannon, St. Joseph's Hospital, first-floor cafeteria, 3rd Thursday, 7-9 P. M. — April 21, "Prenatal Disorders and Congenital Anomalies," R. Stephen S. Amato, M. D.

May 19, "Evaluation of Infertility and Frequent Spontaneous Abortions," Bruce L. Berry, M. D.

June 16, "Sudden Infant Death Syndrome," David Myerberg, M. D.

Cabin Creek, Cabin Creek Medical Center, Dawes, 2nd Wednesday, 8-10 A. M. — April 13, "Overall Outpatient Management of Renal Dysfunctions," Mary Lou Lewis, M. D.

May 11, "Hypertension Update," Steven Grubb, M. D.

Gassaway, Braxton Co. Memorial Hospital, 1st Wednesday, 7-9 P. M. — April 6, "Clinical Intervention in Drug & Alcohol Abuse," Thomas Haymond, M. D.

Madison, 2nd floor, Lick Creek Social Services Bldg., 2nd Tuesday, 7-9 P. M. — April 12, "Allergy Update," Joseph Skaggs, M. D.

May 10, "Common Dermatological Problems," Stephen K. Milroy, M. D.

June 14, "Recently Recognized Sexually — Transmitted Diseases," Thomas W. Mou, M. D.

July 12, "Approach to the Peripheral Vascular Patient," Ali F. AbuRahma, M. D.

Oak Hill, Oak Hill High School (Oyler Exit, N 19) 4th Tuesday, 7-9 P. M. — April 26, "Adolescent Sexuality: Recognizing & Treating Pathological Behavior," T. O. Dickey, M. D., and Art Kelley, M. D.

Welch, Stevens Clinic Hospital, 3rd Wednesday, 12 Noon-2 P. M. — April 20, "Emotional Trauma of Cancer," Sr. Frances Kirtley, R.N., and Sue Warren, M. D.

Whitesville, Raleigh-Boone Medical Center, 4th Wednesday, 11 A. M.-1 P. M. — April 27, "Obesity: Emotional Factors in Compliance," John Linton, Ph.D.

Williamson, Appalachian Power Auditorium, 1st Thursday, 6:30-8:30 P. M. — April 7, "Lower Back Injury," Robert Ghiz, M. D. (a special program in cooperation with Workers' Compensation Fund of West Virginia)

Senate Confirms Physicians For State Agency Roles

Executive appointments confirmed by the State Senate during the recent legislative session included the following:

West Virginia Board of Medicine: S. Eileen Catterson, M. D., Rhodell in Raleigh County (for a term to end September 30, 1985); Thomas Harward, Belington physician's assistant (September 30, 1987); Frank J. Holroyd, M. D., Princeton (September 30, 1987); Dr. Leonard Simmons, Fairmont podiatrist (September 30, 1987); Joseph T. Skaggs, M. D., Charleston (September 30, 1983), and Mrs. Frances Groves, Martinsburg, lay member (September 30, 1987).

West Virginia Racing Commission: Robert S. Strauch, M. D., Martinsburg (March 21, 1986).

Nursing Home Administrator's Licensing Board: Earl Fisher, M. D., Gassaway (June 30, 1986).

Review A Book

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication.

Basic and Clinical Pharmacology, by Bertram G. Katzung, M. D., Ph.D. 815 pages. Price $23.50. Lange Medical Publications, Los Altos, California 94022. 1982.

Nine Months' Reading: A Medical Guide for Pregnant Women, 3rd Edition, by Robert E. Hall, M. D. 178 pages. Price $13.95. Doubleday & Company, Inc., 245 Park Avenue, New York, New York 10167. 1983.

Living With Herpes, by Deborah P. Langston, M. D. 198 pages. Price $7.95. Doubleday & Company, Inc., 245 Park Avenue, New York, New York 10167. 1983.

Current Medical Diagnosis and Treatment, 1983, edited by Marcus A. Krupp, M. D.; and Milton J. Chatton, M. D. 1130 pages. Price $24. Lange Medical Publications, Los Altos, California 94022. 1983.

Act Freezes Hospital Rates, Sets Up Review Board

A 1983 legislative act entitled the West Virginia Health Care Cost Review Authority has frozen all rates for hospital services in effect as of February 1, 1983, and has put a cap on hospitals' gross patient revenues that permits no more than a 12-per cent annual increase.

This same voluminous enactment, effective from its March 12 passage date, sets up as an autonomous entity in the West Virginia Department of Health a three-member West Virginia Health Care Cost Review Authority to review and set hospital rates.

For physicians, key language in a section setting forth the jurisdiction of the review board will be of prime interest. Promulgation of administrative rules and regulations to carry out provisions of the act will be necessary to clarify the eventual effect of the legislation.

The board, or review authority, will—as of July 1, 1984—begin taking jurisdiction as to rates for health services care as they extend to all acute care hospitals in the state except those owned and operated by the federal government.

Other Rates Covered

The act says that board jurisdiction also will extend to other rates as follows:

"Those costs or charges associated with individual health care providers or health care provider groups providing inpatient or outpatient services under a contractual agreement with hospitals (excluding simple admitting privileges) . . .

"The jurisdiction of the board shall *not* (emphasis ours) extend to the regulation of rates of private health care providers or health care groups providing inpatient or outpatient services under a contractual agreement with hospitals when the provision of such service is outside the hospital setting."

The act further stipulates that the board shall not regulate rates of other private health care providers practicing outside the hospital setting: "provided, that such practice outside the hospital setting is not found to be an evasion of the purpose of this article (that setting up the new review authority)."

Compromise Passed in House

The Senate-House compromise that produced the new legislation was passed finally in the House at 11:48 P. M. on Saturday, March 12—just 12 minutes before the end of the regular 60-day session (except for an extension of three days to consider only the state's operating budget for 1983-84).

The voting climaxed feverish activity which reached the panic-button stage in the final few hours, and left in confusion those trying to keep track of what Senate and House conferees were putting together.

Not until Monday, March 14, was it possible to get a reasonably clear picture of all of the provisions of the act, which essentially took the form of the Senate bill passed earlier in the session. There was time for only very sketchy floor explanations of the conference agreement before the bill was passed first in in the Senate, then the House.

Lost in the late shuffle of papers and negotiations, apparently, was a spot for a physician as one of seven voting members on a 12-member advisory council to assist the three-member review authority.

Voting Members

Information available during Saturday evening indicated that the physician spot was assured—but as the final version unfolded, the voting members will include a health insurance industry representative; an administrator of a large hospital; a small-hospital administrator, and four consumers.

The voting members, who will serve along with five heads of state departments, will—like the three board members—be appointed by the governor for specific terms, subject to Senate confirmation.

The new authority also will become the state's health planning and development agency as of July 1, 1984, and take over functions and responsibilities of the certificate of need program for capital expenditures for health care facilities and specified services.

As indicated in another article in this news section, further elaboration on this and other legislation will come in subsequent issues of *The Journal.*

Residents Total Slows

The number of resident physicians in the United States dropped percentagewise from 1976 to 1981, according to recently released figures from the American Medical Association Physician Masterfile. In 1976, 15.4 per cent of all physicians were residents. They made up 13.0 per cent of the physician population in 1981—a drop of 2.4 per cent.

Management Process Seminar Scheduled In Bethany

An April 15-17 weekend of training on "The Management Process for 1983" is being co-sponsored by the Governor's Small and Minority Business Services of the Governor's Office of Economic and Community Development, Bethany College and the United States Small Business Administration. The seminar will be held at the Bethany Leadership Center at Bethany, West Virginia.

Also participating are the West Virginia Small Business Development Centers of Charleston and Clarksburg, and the West Virginia University Business and Management Extension Office.

This program is open to the public, those in business or those who are interested in starting a business.

Book Features State Native

Neurosurgeon Thomas B. Ducker, M. D., a native of Huntington, is featured in a new book, *Not Quite a Miracle* (Doubleday), *The Journal* has learned. Doctor Ducker is Chief Neurosurgeon at the University of Maryland Hospital in Baltimore.

The book was inspired by a Pulitzer Prize-winning story about Doctor Ducker. In that story, the neurosurgeon attempted to remove a deadly blood vessel malformation from the brain of a Baltimore woman. In the new book, Doctor Ducker, a 1955 Huntington High School graduate, is depicted in true stories involving a number of patients.

Enjoying a coffee break during the Mid-Winter Clinical Conference held recently in Charleston are, from left, Drs. James E. Boggs, Ivydale (Clay County), and J. L. Mangus and Ralph H. Nestmann, both of Charleston. Some 250 physicians and others attended the annual continuing medical education event.

Doctor Mufson Presents Paper In Norway

Dr. Maurice A. Mufson of the Marshall University School of Medicine and the Huntington Veterans Administration Medical Center participated in an international scientific symposium in March in Beitostolen, Norway. Doctor Mufson, Chairman of the school's Department of Medicine, presented a paper on "Mycoplasma hominis — A Review of its Role as a Respiratory Tract Pathogen of Man."

He said the meeting provided the most up-to-date review of M. hominis, which can cause pneumonia and tonsillitis and may be linked to serious lung disease in newborns.

The symposium was underwritten by the U. S. Food and Drug Administration, the World Health Organization, the International Organization of Mycoplasmology and the Scandinavian Society for Genitourinary Medicine.

Doctor Mufson is a member of the Program Committee for the annual January Mid-Winter Clinical Conference sponsored by the State Medical Association and the MU and West Virginia University Schools of Medicine.

Anesthesiologists Plan Meeting June 3-4

Speakers from Texas, Pennsylvania, Virginia and Maryland will make up the guest faculty for the annual meeting of the West Virginia State Society of Anesthesiologists June 3-4.

The meeting, "Anesthesia Update '83," will be held in Morgantown at the Holiday Inn.

Guest faculty members will be Yadin David, Ed.D., Texas Heart Institute, Houston, who will speak on "Anesthetic Vaporizers—Performance Assurance Program:" and Drs. Norig E. Ellison, University of Pennsylvania, "New Trends in Intraoperative Blood Transfusions;" David E. Longnecker, University of Virginia, "Anesthetic Considerations in Hypertension;" and Robert W. McPherson, Johns Hopkins University, "The Effects of Anesthetic Agents on Intraoperative Neurological Monitoring."

Speakers from the Department of Anesthesiology at West Virginia University Medical Center will be Drs. Robert Bettinger, "Use of Epidural Narcotics;" Gary S. Sklar, "Control of Adverse Psychological Reactions to Ketamine;" and Barry L. Zimmerman, "Invasive Monitoring: What Do the Numbers Mean?."

Collection Service Outlines Background, Operation

Editor's Note: The I. C. System, Inc., of St. Paul, Minnesota, as reported previously, has been recommended by the State Medical Association as a collection agency for West Virginia physicians. The company has submitted the following release providing additional information about its background and operations.

"Members [of the West Virginia State Medical Association] now have a uniform collection system approved for their use. It employs the latest techniques available, consistent with all requirements and provisions of the increasingly strict laws governing collection practices. The official announcement letter to members outlined the program, but did not go into the particular qualifications of the company chosen to serve the membership, I. C. System, Inc.

"I. C. System has been in the collection business since 1938. It now serves the members of over 1,000 state business and professional associations and societies all across the country. The company is currently collecting at a rate of some $5 million per month in past-due accounts.

"All collection practices, procedures and materials used by I. C. System have been scrutinized by the Federal Trade Commission. So without reservation, all members can be assured that the company is fully aware of what can and cannot be done on behalf of its clients. And I. C. System's hold-harmless indemnity agreement assures members that they are in no danger of legal action resulting from collection activities carried out by the company on their behalf. That's particularly important in this age of consumerism.

Entrusting Name

"Years ago, the most important consideration in selecting a collection service was to determine its ability to collect and its willingness to turn over to the creditor all the money he had coming to him. Today, such selection equally emphasizes the importance of entrusting one's own good name and reputation to the collection service . . . a heavy responsibility.

"Keeping pace with the increases in collections over the years has been development of improved data processing and customer service departments. The company has a modern, tailor-made data processing system backed up by automatic typewriters, microfilm equipment and a complete in-house printing and mailing capability. This enables the company to keep pace with its growth and to respond immediately to customer needs and inquiries.

"The company maintains a staff of customer relations personnel whose job it is to see that all customer inquiries are handled on a "right now" basis. And for those situations in which the mail cannot carry information fast enough, the creditor can telephone the company via their toll-free WATS line system.

"Borrowing from the experience of users in other states, members who install the system should submit nine or more accounts immediately. Even if it's necessary to go back a year or more to come up with that many bad checks or written-off accounts, it's well worth the effort. You can expect as high a percentage of collections on the very old accounts, but the initial heavy use will get your people accustomed to working with the service and thus less likely to overlook future accounts as they become 60 or 90 days past due. A company representative will be happy to spend some time with your people to start things off on the right foot.

"Those members who did not return the inquiry card enclosed with the original announcement letter can arrange to see a representative at a later date by simply contacting the office."

State Psychiatrist To Talk In Ohio, Maryland

Dr. Edmund C. Settle, Jr., of Charleston will be the featured speaker in a one-day educational program sponsored by the Wright State University School of Medicine on April 16 in Columbus, Ohio. The program has been planned for a statewide audience of primary care physicians, and will deal with the care of psychiatric patients in primary practice.

The meeting is under the combined auspices of the Ohio Department of Health, the Departments of Psychiatry and Family Practice of Wright State University School of Medicine, and the School of Nursing of Wright State.

Doctor Settle, who is in private practice and is Clinical Associate Professor of Psychiatry at West Virginia University, also will be serving as moderator of a two-day symposium, "Affective Disorders Reassessed: 1983," at Taylor Manor Hospital in Ellicott City, Maryland, on April 8 and 9. This program will feature speakers with expertise in biologic aspects of psychiatry from the United States and Canada.

Child Abuse CME Program Set In Summersville

A continuing medical education program on "Child Abuse and Neglect" will be presented in two sessions by the WVU Medical Center/Charleston Division on April 12 and 19 in the Nicholas County Courthouse, Summersville. The time for both sessions will be from 7 to 9 P. M. The featured speaker will be Kathleen Preville, M. D., Coordinator of Pediatric Clinics at the Charleston Area Medical Center.

The first session will focus on the medical aspects of child abuse and, the second, on consideration of the establishment of a county treatment plan. Co-sponsor for the program is a consortium of local civic groups and governmental agencies. All health professionals are welcome.

The program is approved for four credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association, and .4 Continuing Education Units.

For more information, contact Beth Jordan, R. N., at 872-4649 in Summersville, or John Aukerman at 347-1294, Division of Continuing Education, WVU Medical Center/Charleston Division.

MU Succinimides Study Grant Received

A Marshall University School of Medicine researcher has received a $201,997 grant to study why chemical compounds used as anti-epileptic drugs and fungicides (and also found in cigarette smoke) sometimes cause kidney damage.

Dr. Gary O. Rankin, Associate Professor of Pharmacology, will study succinimides, a group of compounds with similar structures. He said scientists have known since the 1950s that some succinimides cause kidney damage. However, he believes very few researchers are trying to find out why they are toxic — and why others, such as the principal anti-epileptic drugs, are not.

Doctor Rankin said kidney damage from succinimides isn't a big problem in the United States, but he believes it could become one. He noted that 1,000 succinimide-based drugs for epilepsy were introduced for testing between 1966 and 1976.

His three-year grant is funded by the National Institutes of Health.

Medical Meetings

April 7-8—WV Chapter, Am. Academy of Pediatrics, Beckley.

April 11-14—Am. College of Physicians, San Francisco.

April 15-17—WV Chapter, AAFP, Morgantown.

April 16-21—Am. Academy of Pediatrics, Philadelphia.

April 17-21—Am. Urological Assoc., Las Vegas.

April 17-22—Operative Treatment of Fractures & Nonunions (Johns Hopkins University), Hot Springs, VA.

April 18-22—Am. Roentgen Ray Society, Atlanta.

April 21-23—Medical & Chirurgical Faculty of MD, Cockeysville.

April 22-24—Medical Staff Leadership Seminar (Southern Medical Assoc.), Hilton Head, SC.

April 23—WV Diabetes Assoc., Charleston.

April 24-28—Am. Assoc. of Neurological Surgeons, Washington, D. C.

May 2-6—Am. Psychiatric Assoc., New York City.

May 4-7—WV Chapter, Am. College of Surgeons, White Sulphur Springs.

May 6-8—Southern Medical Assoc. Regional Postgraduate Conference, Lexington, KY.

May 8-12—Am. College of Obstetricians & Gynecologists, Atlanta.

May 13-14—Topics in Cardiovascular Diseases (Am. Heart Assoc.), Baltimore.

May 19-20—National Conference, Breast Cancer (Am. Cancer Society), Boston.

May 20-22—Am. Counseling Assoc., Morgantown.

May 26-28—Am. Assoc. of Genitourinary Surgeons, White Sulphur Springs.

June 19-23—Annual Meeting of AMA House, Chicago.

Aug. 25-27—116th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

Sept. 29-Oct. 2—Am. Society of Internal Medicine, San Francisco.

Oct. 16-21—Am. College of Surgeons, Atlanta.

Nov. 6-9—Scientific Assembly, Southern Medical Assoc., Baltimore.

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WVU Medical Center
–News–

Compiled from material furnished by the Medical Center News Service, Morgantown, W. Va.

Unemployed Told Not To Go Without Treatment

Physicians in WVU's Medical Group Practice have told their patients that financial difficulties should not stop them from seeking needed medical services.

In a letter sent to each patient, the doctors note that special financial arrangements can be made to cover bills for necessary treatment.

"Patients who bring to our attention their financial difficulties resulting from unemployment can make some type of mutually agreed on payment schedule tailored to the patient's current situation," said Robert D'Alessandri, M. D., Chief of the Section on Comprehensive Medicine.

"We do not want our patients to hesitate to seek needed medical care because of financial problems beyond their control. We have sent letters to all patients of the Medical Group Practice explaining this policy."

Up to 1,100 Seen Monthly

Between 1,000 and 1,100 patients are seen each month in the Medical Group Practice, which is the outpatient general practice unit of the WVU Medical Center.

Conrad Pesyna, Business Manager for the Medical Group Practice, says that since November his office has been monitoring the number of patients having particular difficulty in making payments, and the number has increased significantly.

"All of our patients are screened at each visit to determine their payment status. Those with financial problems are routed to the business office to make payment arrangements before seeing their doctor.

"This has been our policy all along but since so many more patients are finding themselves in a financial bind and some are losing their health insurance coverage, we're making a special effort to assure our patients that special arrangements can be made if necessary," Pesyna explained.

Seven Students Elected To AOA, National Honor Society

Seven third-year students in the WVU School of Medicine have been elected to the national honor medical society, Alpha Omega Alpha.

Michael Nunley and Richard Weidman, both of Charleston; Richard Loeser, Huntington; Patrick Allender, Valerie Lazzell and Frederick Zeller, all of Morgantown, and Salvatore Parascandola, West Babylon, New York, are WVU's newest AOA members.

They bring the total student membership to 20, joining six from the fourth-year class who were elected last fall, and seven elected in their third year last spring.

The others are Stephen Powell, Scott Depot, President; Anne C. Cutlip, Morgantown, Vice President; Carolyn Looney, Van Sant, Virginia, Charleston Division Vice President; Michael T. Angotti, Clarksburg; Linda Gray, Elm Grove; Lynn H. Harris, Baltimore; Richard J. Jackson, Martinsburg; Gary Renaldo and Ralph A. Sellers, Fairmont; Gregory D. Snodgrass, Gauley Bridge; Jack Steel, Barrackville; Vincent Traynelis, Morgantown, and Daniel W. Wilson, St. Marys.

The WVU chapter also elected a faculty member, Dr. John A. Belis, Associate Professor of Urology, and an alumnus, Dr. Dominic Gaziano of Charleston.

Better Eye Care For Workers

A pilot program to encourage effective eye care for industrial workers has been launched by the American Academy of Ophthalmology under the direction of a WVU eye specialist, Dr. George W. Weinstein, Chairman of Ophthalmology. The project is under way for an estimated 35,000 employes of U. S. Steel Corp. and Duquesne Light Co. in the Pittsburgh area.

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Third-Party News, Views and Program Concerns

AMA Fears Loss Of Quality If DRGs Approved

The American Medical Association has testified against the Reagan Administration's proposal to base Medicare payments to hospitals on the patient's diagnosis.

Appearing recently before the House Ways and Means Subcommittee on Health, Jerald Schenken, M. D., a pathologist from Omaha, Nebraska, and Vice Chairman of the AMA's Council on Legislation, recommended that the committee "reject the Administration's proposal to impose an untried system across the nation."

He called instead for more prospective payment demonstration projects and further analysis of the demonstration projects already in place.

The AMA opposes "a radical change in the Medicare hospital reimbursement system without assurances that quality of care will be maintained," he explained.

467 DRGs Proposed

Doctor Schenken said the proposal, which would set a price for each of 467 diagnosis-related groups (DRGs) and which the Administration wants to implement nationwide October 1 "has never been tried, even on a limited scale."

The DRG experiment in New Jersey, which began three years ago, differs significantly from the Administration proposal, and in any event, the New Jersey experiment has not been evaluated yet, he said.

The Administration's proposal, which was moving toward congressional approval as part of the Social Security package, aims to control the spiraling costs of Medicare, which now devotes 68 per cent of its $60-billion budget to hospitals.

Proponents of the plan say that if hospitals were paid per DRG, they would have an incentive to be efficient. Hospitals now are reimbursed by Medicare on the basis of their costs.

The DRG system divides illness into 467 categories by primary and secondary diagnoses, the primary procedure used (if there is surgery), the age of the patient and the patient's discharge status. DRG 167, for example, is an appendectomy without complicated principal diagnosis, complications, or associated illness for a patient under 70.

Hospital Association Proposal

The American Hospital Association also has proposed a DRG-based prospective payment system for Medicare, although it differs from the Administration's proposal on several points, particularly as to how prices for each DRG should be determined.

Doctor Schenken said the AMA "has some of the same concerns about the AHA proposal as it has about the Administration's." He added, however, that he saw merit in experimenting with the proposal.

The AMA supports experimentation with prospective payment systems that create incentives for hospitals to be more cost conscious, Doctor Schenken testified. He called upon the committee to authorize that the Administration's proposal "and other prospective pricing proposals" be demonstrated on a limited scale in various states before being considered for national implementation.

Quality of Care Reduced

Doctor Schenken said that if a hospital were underfunded by Medicare, it would respond by shifting costs to other payers, deferring such costs as maintenance, reducing nursing and other essential patient care staff, and postponing or eliminating necessary modernization and technological improvements, thus depriving patients of the highest quality of care.

"In extreme cases, hospitals providing essential care could be forced to close," he said.

He added that the AMA was concerned that the Administration's proposal could foster a two-tiered system of health care, with one level of care for private-pay patients and one for Medicare patients.

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Obituaries

DANIEL N. BARBER, M. D.

Dr. Daniel N. Barber of Charleston, Treasurer of the State Medical Association from 1958 to 1965, died on February 20 in a hospital there. He was 85.

A native of Charleston, he was the son of the late Dr. Timothy L. Barber, who founded the Kanawha Valley Hospital in Charleston. He was a member of the board of directors of the hospital, which now is located in a new building in Charleston.

Doctor Barber, a general practitioner, began practice in 1932 in Widen (Clay County), moving back to Charleston after several years.

He was graduated from West Virginia University, and received his M. D. degree in 1932 from Harvard Medical School. He interned at Hartford (Connecticut) Hospital.

A veteran of World War 1, Doctor Barber was an honorary member of the Kanawha Medical Society, West Virginia State Medical Association and American Medical Association.

Surviving are the widow and two sons, James D. Barber, Ph.D., a professor at Duke University, and Timothy Barber, Charleston lawyer.

* * *

MAX O. OATES, M. D.

Dr. Max O. Oates, retired Martinsburg surgeon, died on February 9 at his home. He was 85.

He devoted most of his adult life to the development and operation of City Hospital, for which he served as Chief Executive Officer from 1951 until his retirement in 1976. He previously had been Superintendent of the hospital (1941-1951).

Doctor Oates was appointed Medical Director of the hospital in 1972. Following retirement, he continued to serve as hospital Treasurer and as a member of the board of trustees until his death.

Other posts held with the hospital included those as Chairman of the Department of Surgery, and President of the medical staff.

Doctor Oates was a Past President of the Eastern Panhandle Medical Society, and a Fellow of the International College of Surgeons and the International Academy of Proctology.

Born in Capon Bridge (Hampshire County), he received both his undergraduate and M. D. (1929) degrees from Johns Hopkins University. He interned at Johns Hopkins Hospital, and took his residency at Duke University Hospital.

Doctor Oates was an honorary member of the Eastern Panhandle Medical Society, West Virginia State Medical Association and American Medical Association.

Survivors include the widow; two sons, Max O. Oates, Jr., of Flint, Michigan, and Dr. Theodore K. Oates II of Rochester, New York; and a daughter, Mary Elizabeth Oates of Williamsport, Pennsylvania.

* * *

LEO H. T. BERNSTEIN, M. D.

Dr. Leo H. T. Bernstein, Martinsburg internist, died on February 13 at his home there. He was 64.

Doctor Bernstein was a member of the State Medical Association's Council from 1978 to 1982.

The first internist in Martinsburg and a member of the Berkeley County Board of Education, Doctor Bernstein began practice there some 30 years ago.

He was a Past President of the Eastern Panhandle Medical Society, and was Chief of Staff at City Hospital in Martinsburg.

Born in New York City, Doctor Bernstein was graduated from Rutgers University in 1938 with a B.S. degree, received a Ph.D. in bacteriology in 1941 from Johns Hopkins University, and his M. D. degree in 1949 from the University of Utah.

He interned at Salt Lake County (Utah) General Hospital, and took residencies at George Washington University Hospital in Washington, D. C., and at Newton Baker Veterans Administration Medical Center in Martinsburg.

A veteran of World War II, he was a Diplomate of the American Board of Internal Medicine.

Doctor Bernstein was a member of the Eastern Panhandle Medical Society, West Virginia State Medical Association and American Medical Association.

Survivors include the widow, Dr. Jean P. Lucas, an internist at the Martinsburg VA Medical Center; four sons, Shawn Bernstein of Washington, D. C.; Joel Bernstein of Corona Del Mar, California; John Bernstein of Klamath Falls, Oregon, and Ted Bernstein, at home; and one daughter, Leigh Bernstein, at home.

* * *

JOHN C. GODLOVE, M. D.

Dr. John C. Godlove of Martinsburg, a surgeon, died on February 11 in a Washington, D. C., hospital. He was 71.

A native of Martinsburg, Doctor Godlove was graduated from Dickinson College in Carlisle,

Pennsylvania, and received his M. D. degree in 1944 from the University of Maryland. He took his postgraduate training in the Baltimore area.

A veteran of World War II, Doctor Godlove was an honorary member of the Eastern Panhandle Medical Society, West Virginia State Medical Association and American Medical Association.

Survivors include the widow; two daughters, Linda Godlove of New York City and Mrs. Tootie Ridenour of Williamsport (Grant County); one son, John C. Godlove II of Harrisburg, Pennsylvania, and one brother, Arnold L. Godlove of Hagerstown, Maryland.

* * *

PETER D. CRYNOCK, M. D.

Dr. Peter D. Crynock, retired Morgantown general practitioner, died on February 19. He was 75.

Following service with the U. S. Army Medical Corps during World War II, Doctor Crynock was a company doctor at the Koppers Coal Company Mine at Grant Town in Marion County, and later was company doctor with Pursglove Coal Company and Christopher Coal Company in Monongalia County.

After leaving mine practice, he entered private practice in Morgantown, and was a staff member of the former Vincent Pallotti Hospital and at Monongalia General Hospital until his retirement.

Doctor Crynock, who was born in Dearth, Pennsylvania, was graduated from West Virginia University, and received a Doctor of Medicine and Master of Surgery (M. D. C. M.) degree in 1935 from Dalhousie University in Halifax, Nova Scotia, Canada. He interned at institutions in Nova Scotia. Doctor Crynock also earned a degree in science from the University of Virginia.

He held life memberships in the U. S. Military Surgeons and the U. S. World Medical Association; was a member of the Dalhousie Alumni Association and its Emeritus Club; held a fellowship in the Royal Society of Health, Patron of her Majesty the Queen, in London, England; and was an honorary member of the Monongalia County Medical Society, West Virginia State Medical Association and American Medical Association.

Survivors include the widow; one brother, John E. Crynock of Morgantown, and five sisters, Anna Crynock, Mary Sypolt, Susan Crynock and Kathryn Crynock, all of Morgantown, and Emily Crynock of Chicago.

County Societies

McDOWELL

The McDowell County Medical Society met on February 9 at Stevens Clinic Hospital in Welch.

The American Medical Association video cassette program on dizziness was presented.

The meeting was preceded by a social hour and covered-dish dinner provided by the Auxiliary.—John S. Cook, M. D., Secretary.

* * *

FAYETTE

The Fayette County Medical Society met on February 2 at the Plateau Medical Center in Oak Hill.

The guest speaker was Dr. Hassan Amjad of Beckley. His topic was "Cancer of the Lung." —Serafino S. Maducdoc, Jr., M. D., Secretary-Treasurer.

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***CARIBBEAN CONFERENCE** — July 27–Aug. 6, 1983. Visit St. Thomas, Antigua, Barbados, Martinique, and St. Croix.

MEDITERRANEAN CONFERENCE — Aug. 20 — Sept. 3, 1983. Visit Major Cities in Italy, Greece, Egypt, Israel, Turkey, Yugoslavia.

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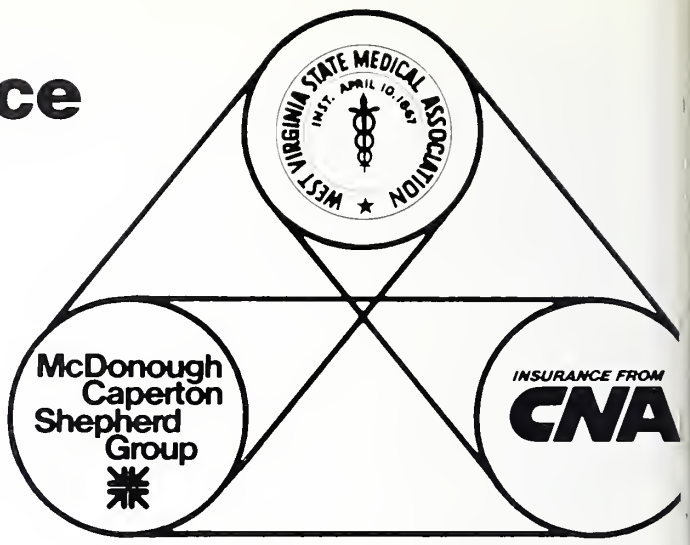

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The West Virginia Medical Journal

Vol. 79, No. 5 May, 1983

Hypokalemic Myopathy In Hyperemesis Gravidarum: Its Historical Significance*

JACK E. RIGGS, M. D.
Department of Neurology, West Virginia University School of Medicine, Morgantown

ROBERT C. GRIGGS, M. D.
Department of Neurology, University of Rochester School of Medicine and Dentistry, Rochester, New York

LUDWIG GUTMANN, M. D.
Department of Neurology, WVU School of Medicine

The occurrence of hypokalemic myopathy in a woman with hyperemesis gravidarum is reported. Although previously unrecognized, hypokalemic myopathy may have been a relatively common cause of weakness in some cases of hyperemesis gravidarum.

Muscle weakness complicating pregnancy was a well-recognized occurrence during the nineteenth century. In von Hosslin's review of 494 such cases the causes of weakness included trauma, infection, focal neuropathies, and polyneuropathies.[1] The polyneuropathy developing during pregnancy was referred to as the polyneuritis of pregnancy, accounting for approximately 10 per cent of the cases in von Hosslin's review.[2]

As early as 1889, an association was noted between hyperemesis gravidarum and the polyneuritis of pregnancy,[3] and this subsequently was firmly established.[2] Since hyperemesis gravidarum initially was thought to represent a toxic manifestation of pregnancy, it was hypothesized that the polyneuritis of pregnancy had a similar etiology.[2] However, due to pathological and clinical similarities, the polyneuritis of pregnancy has been considered a nutritional-deficiency polyneuropathy since the 1930s.[4-6] In some cases of the polyneuritis of pregnancy, however, sensory abnormalities and decreased reflexes were conspicuously absent, and a much more rapid resolution of motor weakness occurred following abatement of the hyperemesis than would have been expected with a neuropathy.[2] This suggests that in at least some cases of hyperemesis gravidarum there may have been a mechanism of motor weakness other than polyneuropathy.

We now report a case which may shed some retrospective insight into the association between motor weakness and hyperemesis gravidarum.

Case Report

A 27-year-old, gravida 4, para 1, abortus 2, four-month pregnant woman was referred for neuromuscular evaluation because of progressive muscle weakness and an elevated creatine kinase (CK - 1156 IU/ml, nl 7-89). Previous medical history was unremarkable. The only medication on admission was a daily vitamin tablet.

Her pregnancy had been complicated by persistent nausea and vomiting for three months. She had been vomiting 10 to 12 times per day during the two weeks preceding her hospital admission. Four weeks before admission, she noted tenderness of her thigh muscles and difficulty climbing stairs and lifting her arms above her head. She became so weak that her husband

*Presented in part at the 34th Annual Meeting of the American Academy of Neurology, May 1, 1982, Washington, D. C.

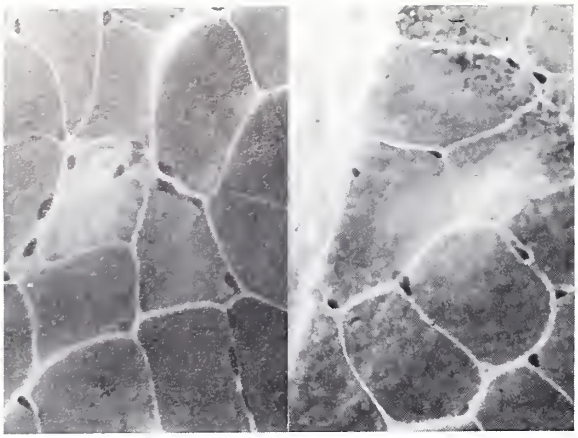

Figure. Biceps muscle. Composite demonstrating rare isolated vacuolated muscle fibers (modified Gomori trichrome, X126).

had to carry her about their home. She had lost 13 pounds during her pregnancy. There was no history of fever, joint symptoms, skin rash, or dark urine.

On admission she was very thin. Her abdomen was soft and the uterus was palpable below the umbilicus. Bowel sounds were present. General examination was otherwise unremarkable. Muscle bulk was slender and tone was normal. Her thigh muscles were tender to palpation. She was unable to lift her head off the bed when supine, squat, or step up onto an eight-inch stool. Muscle strength (Medical Research Council Scale) was grade 4- to 4 proximally except for the neck flexors (grade 2) and hip flexors (grade 3). The remainder of the neurologic examination, including reflexes, was normal.

Laboratory Studies

Admission laboratory studies showed: K - 1.9 mEq/L, Na - 140 mEq/L, CO_2 - 25 mEq/L, Cl - 103 mEq/L, BUN - 5 mg/dl, Hct - 31 per cent, CK - 1580 IU/L (MB fraction negative), LDH - 269 IU/L (nl 100-225), and AST - 116 IU/L (nl 7-40). Urine was negative for hemoglobin and myoglobin. Thyroid, renal, adrenal, liver, immunologic, and other electrolyte studies were normal. Electrocardiogram showed changes consistent with hypokalemia.

Treatment and Results

After admission, 200 mEq of oral potassium chloride (K-lyte/Cl^R) was administered over eight hours, at which time serum K had risen to 3.3 mEq/L. Her strength improved rapidly during the first two days after admission. EMG studies two days after admission were normal. Left biceps muscle biopsy done three days after admission demonstrated a mild vacuolar myopathy (Figure). Eight days after admission, CK was 21 IU/L. One month after admission her strength had returned to normal. Her vomiting ceased immediately after the hypokalemia was corrected and did not recur (see Table for clinical and laboratory summary). The patient gave birth to a normal baby girl five months after admission. A diagnosis of hypokalemic myopathy complicating hyperemesis gravidarum was made.

Discussion

In 1951, Bergquist first reported the occurrence of hypokalemia in hyperemesis gravidarum and speculated that potassium deficiency was responsible for the associated muscle weakness in his case.[7] He also suggested that motor weakness present in some previously reported cases of the polyneuritis of pregnancy may actually have been related to potassium deficiency produced by the persistent vomiting in hyperemesis gravidarum.[7] Appearing soon were two additional reports also describing muscle weakness in hyperemesis gravidarum with associated hypokalemia.[8,9] In these cases, rapid improvement of muscle strength followed correction of the hypokalemia.[8,9] In 1955, significant hypokalemia was reported in nine of 10 women with hyperemesis gravidarum, suggesting that hypokalemia is usually present in hyperemesis gravidarum.[10]

TABLE

Clinical and Laboratory Summary

	CPK (IU/L), nl 7-89	*K(mEg/L), nl 3.5-4.5*	*Vomiting*	*Weakness*
1 day before admission	1156	2.0	present	severe
Admission	1580	1.9	present	severe
6 hours after admission	—	1.7	present	severe
11 hours after admission	—	3.3	absent	moderate
2 days after admission	—	3.6	absent	moderate
4 days after admission	202	3.8	absent	mild
8 days after admission	21	3.8	absent	minimal
1 month after admission	—	—	absent	none

Although hypokalemia has been associated with hyperemesis gravidarum, a specific myopathy in hyperemesis gravidarum has not been previously identified as a cause of weakness. Hypokalemic myopathy in man initially was reported in 1955, the same year as the last report to note specifically hypokalemia in hyperemesis gravidarum.[10] This coincidental disappearance of motor weakness from the hyperemesis gravidarum literature and the initial description of hypokalemic myopathy presumably is related to improved obstetric fluid, electrolyte, and nutritional management. This case provides the first documentation that hypokalemic myopathy, in addition to nutritional neuropathies, may be a cause of muscle weakness in hyperemesis gravidarum. Hyperemesis gravidarum previously has not been associated with hypokalemic myopathy.[12]

Due to the incidence of hyperemesis gravidarum (about one case per 1,000 births)[13] and the frequent significant hypokalemia in hyperemesis gravidarum,[10] hyperemesis gravidarum may have been a relatively common, although previously unrecognized, cause of hypokalemic myopathy. Conversely, hypokalemic myopathy may have been a relatively common, although previously unrecognized, cause of weakness in some cases of hyperemesis gravidarum.

Generic drug listing: potassium chloride (K-lyte/Cl®).

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Diagnosis And Treatment Of Alzheimer's Disease

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By the year 2030, 25 million of the estimated 55 million elderly will be 75 years of age and older. The major health problem facing this group is dementia. If this trend continues, dementia will be third only to cancer and heart disease as a cause of mortality and morbidity in this group. Approximately four million people 65 and older have dementia of the Alzheimer's type.

In this paper, the features of Alzheimer's disease and the various diagnostic tools are discussed. The authors compare the disease process with the depressive illness, keeping in mind that dementia is a clinical diagnosis. Recommendations for maintenance and treatment are provided.

It is estimated that 11 per cent (25 million) of the U. S. population is over 65 years of age; however, this group accounts for 30 per cent of all personal health care spending and 55 per cent of all federal health dollars. It is further estimated that of the 287 billion dollars spent annually for personal health care, approximately 75 billion is for the elderly, especially those 75 and over. This, by far, is the most rapidly growing segment of the population. By the year 2030, 25 million of the estimated 55 million elderly will be 75 and older.

While growth of this segment is taking place at an amazing rate, knowledge of the aging process, including the diagnosis, ramifications and treatment of its diseases, is being assimilated all too slowly. "Ageism," prejudice against the elderly, is common and rampant among all professionals including physicians. "Ageism" contributes to the frustration that "nothing can be done" or "nothing should be done." Treatment is seen as an "unworthy investment of time and effort." These attitudes often encourage hostility, paranoia, depression, abandonment and indifference, and have been linked to "familial elderly abuse." This is a sinister situation which poses a serious dilemma to care providers who have turned increasingly to the family as "the last line of defense in the care of the aged."

The country's nursing home expenditures have been rising at an annual rate of 16 per cent. Today, with 1.3 million people in nursing homes, the spending level is nearing $22 billion; by 1990, it is estimated to reach $75 billion. By that time nearly 10,300 geriatricians will be needed as consultants and, in complex cases, as primary care practitioners. According to a 1977 American Medical Association survey, fewer than 700 physicians identified themselves as having a primary, secondary, or tertiary specialty in geriatrics.

Research Lags

Fifteen per cent of people age 65 years and over have some form of psychiatric impairment and, of these, three per cent require institutionalization. Five per cent of people age 65 and older, approximately four million, have dementia of the Alzheimer's type, a disorder that is marked by progressive mental deterioration of memory and judgment. Of these, one million are so severely affected that they cannot manage themselves. Despite the severity of the problem, only $16 million was spent on dementia research last year, as compared to the $22 billion spent in nursing homes.

Alzheimer's disease, a form of primary neuronal degeneration, was first described by Alzheimer, in 1907, in a 51-year-old female. The female died four and one half years later, and the classical histopathology was determined. It is the most common form of irreversible dementia, accounting for 50 to 70 per cent, as opposed to multi-infarct dementia, which represents 15 to 20 per cent.

Early diagnosis of Alzheimer's is essential and of paramount importance because treatment differs. Unfortunately, referral is often too late or delayed: consequently, the illness has progressed too far for any improvement. This has a detrimental effect on the family and their morale, as well as on the community. In turn, feelings of rejection in the patient and his further deterioration occur due to poor management. Paradoxically, it has been shown that differentiation is easier in the earlier stages of the disease, thereby allowing more humane,

compassionate, and cost-effective treatment, preferably at home by caring relatives and neighbors.

In this paper, the authors discuss the clinical features of Alzheimer's disease, the various diagnostic tools, and compare the disease process with the depressive illness. The authors also provide recommendations for maintenance and treatment.

Diagnosis

To establish a diagnosis of Alzheimer's disease, a biopsychological, social approach which entails a life history of the patient is necessary. A thorough physical examination, including a detailed drug history, is essential. The following laboratory examinations are recommended in all cases of suspected Alzheimer's disease:

- CBC
- Electrolytes
- SMA 12
- EKG
- Serology
- Urinalysis
- T_4
- TSH
- Serum B_{12}
- Folic Acid
- Serum Aluminum
- Psychological Tests
- Chest X-ray
- CT Scan
- —Dexamethasone Suppression Test (a level of over 6 μg/dl of serum cortisol is indicative of a depressive illness)
- —Serum Magnesium (as excessive use of laxatives or antacids can lead to magnesium toxicity)
- —EEG (if the EEG appears worse than the mental state, then dementia is likely to be secondary rather than indicative of Alzheimer's disease)
- —Occult Blood Stool x 3 days (to detect occult cancers, especially of the colon)

A thorough evaluation may be expensive on a short-term basis; however, it is cheaper in the long run, especially if an early diagnosis reveals a treatable condition. It is estimated that 20 to 25 per cent of the patients diagnosed as having organic brain syndrome (OBS) have a causative factor which is treatable, resulting in amelioration of the symptoms. Tests can be completed on an outpatient basis.

Another essential diagnosis to be included and excluded in all cases of dementia is depression, which can mask chronic OBS. In our practice we assume that all patients suffering from dementia have depression unless proven otherwise. When the dementia is accompanied by psychomotor retardation, the possibility of depression or multi-infarct dementia should be explored. With depression, the onset is sudden and the patient is better at night. The depressed patient tends to surrender to the disability, whereas the demented patient fights it. When depression is treated successfully, immense gratification and reward are by-products to all concerned.

Kiloh[1] emphasized the danger of relying on psychological testing for diagnostic purposes. Some of his patients on psychometric testing showed alterations typical of organic deterioration: normal restitution was attained after treatment of depression. Similarly, CT scans showing cerebral atrophy could not be judged as a sign of dementia. Cerebral atrophy is ubiquitous after the age of 50, even in intellectually intact persons. Dementia is a clinical diagnosis, and a holistic approach is essential. The single best diagnostic tool is the mental status.

After the diagnosis of Alzheimer's disease or dementia has been made, the family is faced with several decisions. If the person has been living alone, can he or she continue in that situation? Another frequent uncertainty is the ability of family members to care for the patient

TABLE 1

Comparison of the Clinical Features of Alzheimer's Disease with Other Organic Brain Syndromes

A. Early Phase	*Alzheimer's Disease*	*Non-Alzheimer's Disease*
I. Memory Loss	Early, insidious, patient becomes less spontaneous, is irritable, seeks and prefers familiar surroundings, may go unnoticed by relatives, covers up his loss, may show "catastrophic reaction"	Late
II. Precipitating Factors	May be present during bereavement, children leaving home, etc.—any situations involving interruption of the patient's daily routine	Less Often
III. Apraxia	Early, but after memory loss, may present as dressing apraxia or inability to arrange objects in space	Late
B. Intermediate Phase	Emotional lability, shallow affect, irritability and insensibility, increasingly self-absorbed, speech may be affected, needs management in specialized services, as banking, etc.	Also Seen Here
C. Late Phase	Market changes in personality, confabulation, incontinence, preservation of social competence, hematological signs present, may show psychotic features and neurological deficits	Early

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TABLE 2

Comparison of the Clinical Features and the Aspects of Treatment of Depression and Dementia.

	Depression	*Dementia*
Age	Earlier	Late, usually after 75
Onset	Recent, rapid, following a precipitating event, may regress and may become vegetative	Insidious, no broad linkage to a precipitating event, happier and active
Past History	Of depression with behavior disturbance	Absent
Family History	Of depression	Of dementia
Memory Loss	Complains bitterly of memory loss which is generalized, poor concentration, puts no effort in answers, gives in easily and says, "I don't know."	Rarely complains, covers up memory loss
Affect	Pervasive, depressed	Emotional lability, appears happier in general, shallow, may show depressive content in early part of the disease
Treatment	DST, trial of antidepressants (adequate dose for 3-6 weeks), psychotherapy (especially cognitive therapy)	Supportive psychotherapy involving the individual, family and significant others
Miscellaneous	Family less tolerant of global disinterest	Family tolerant of forgetfulness and often say, "It's his age."
	Other features of depressive illness present	Absent
	Seek treatment earlier	Avoid treatment

in their homes. These questions need to be discussed with those who know the patient well. The primary care physician and the family are in the best position to deal with these concerns.

Recommendations

At the present time there are no hard and fast rules on how to care for the patient, only recommendations. In each case consideration should be given to the individual needs of the people who are involved and the practicality of the situation.

A. Medical

1. The primary care physician should avoid polypharmacy and schedule periodic physical assessments.
2. Medication needs to be kept to a minimum, and nutrition, hydration and constipation need to be monitored.
3. The presence of depression as a psychiatric syndrome as well as other psychiatric syndromes should be thoroughly evaluated.
4. The primary care physician needs to attend to other physical or mental disorders.
5. The use of neuroleptic drugs and, in some instances, electro-convulsive therapy, may eliminate the depressive features. Antidepressants with the least anticholinergic side effects are recommended in low doses.
6. Cerebral vasodilators are valueless.
7. Hydergine, an ergot alkaloid, has been shown to be beneficial in a small number of selected cases, especially in the early phase.
8. Lecithin, choline, and physostigmine have shown controversial and unimpressive results.

B. Psychosocial

1. In the early stages of the disease, the patient may be able to continue his personal hygiene as usual; however, in the middle and latter stages, he may need assistance. Clothing choices should be kept to a minimum, and old clothing or clothing of the wrong size should be discarded. Allow the patient to do as much of his personal hygiene as possible, and assist when necessary.
2. Incontinence often is frustrating to the family. Initially, loss of bladder control may occur only occasionally; however, as the disease progresses it may become more frequent. Regular at-

tendance to the bathroom, restricting fluids in the evening, and going to the bathroom before bedtime should be done routinely. When needed, adult-size diapers may be used. Avoid fecal impaction by regular toilet-training, well-balanced meals with high fiber content, prune juice, and Metamucil.® Fecal impaction can be a cause of confusion.

3. Regular sleep hygiene should be encouraged. Daytime napping and sleeping aids should be avoided. Where needed, use L-Tryptophan (a natural amino acid present in milk, cheese, fish, etc.) in a dose of 1000-1500 mg., given 1-2 hours prior to bedtime.
4. Regular exercise when possible (e.g., a daily walk with supervision) is strongly advised.
5. As the disease progresses, the patient becomes increasingly forgetful and shows signs of memory impairment, especially for recent events. He may need gentle reminders to do things he previously did routinely. Articles such as glasses and dentures may become misplaced. The family may need to take the responsibility of placing the dentures and glasses in a certain place at night and giving them to the patient in the morning. Orienting the patient to time, place and the other person(s) present also will reduce stress. This can be done, for example, by saying, "We will now go into the kitchen for lunch." Visitors, including family members, should be introduced by name.
6. In many communities there are voluntary groups (The Alzheimer Society) whose members share their common experiences in caring for persons with Alzheimer's disease. The group provides information on new advances made in research, and services that are available; however, the most important aspect of the group is that of emotional support for its members. It is the common sharing that boosts the members' morale.

Summary

Whereas the life expectation for patients suffering from dementia used to be two to three years, advancements in medicine now have extended it to 10 years. Dementia has become a major health problems and, if the trend continues, will be third only to cancer and heart disease as a cause of mortality and morbidity by the year 2000.

Economists may question the cost-effectiveness of providing expensive and demanding services to those who will never be productive members of society again, but health care cannot be measured in dollars alone. The quality of life is important; and, if we can improve this by rehabilitative and diversional facilities, the authors believe the money is well spent. Unfortunately, in the authors' opinion, some of the blame for inadequate care for the elderly can be leveled at the U. S. Health Care Financing Administration, which controls Medicare and emphasizes "cost containment" above all else. Many insurance carriers conform to the guidelines of Medicare. Although Medicare reimburses medical and surgical services at 80 per cent of all customary and reasonable fees with no yearly maximum, it reimburses only 50 per cent and up to $250 per year for psychiatric consultation and care. This has resulted in inappropriate use and overuse of psychotropics with some deleterious effect. This may appear cheaper in the short run, but the resulting increase in morbidity and mortality adds significantly to long-term care, to say nothing about the tragic waste of human potential.

New Programs Will Be Needed

Research into the cause and treatment of Alzheimer's disease and similar diseases is being conducted throughout the country. Ultimately, prevention and treatment will be the answer. Until this can be accomplished, however, the care and management of a person with these diseases will be a major concern of families and health care providers. Health and social programs will have to be developed and expanded to meet these needs.

Presently, there are several programs being utilized throughout the country which deserve further attention. Day care for the elderly is similar to the day care programs for children; however, the providers are specifically trained in the needs of geriatric persons. This allows the family members to continue employment while being reassured that the elderly relative is being looked after. Also, home care programs and tax breaks are being explored to provide financial incentive to the family members for keeping elderly persons at home. Both of these programs, and others, should be further developed, and the need for them documented.

Each concerned person has a right, and somewhat of a responsibility, to let the policy makers know that the need exists. Not until enough people do so will improved and new programs become a reality.

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Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing the most commonly known trade-name drug of that designation. In addition, a listing of all generic drugs mentioned in the article, with their trade-name equivalents, should appear at the end of the article.

A short abstract summarizing the manuscript should be included. This should be typed in double space on a separate page.

Authors are requested to submit a carbon copy with the original.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for reproduction should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. Cost of printing black and white photos in excess of 4 will be billed to author, and no more than 25 references will be published free of charge to the author. A legend should be provided for each illustration and, preferably, attached to it.

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A message from . . .

The President

THE 'COST CONTAINMENT' (?) BILL

This month, I intended to discuss involvement, but after visiting Greenbrier Valley and Wetzel County Medical Societies, there were many questions on the so-called hospital cost containment bill. I would like to address it this month, with involvement to come in the future.

We must first realize "cost containment" is a misnomer for the legislation enacted in the last 16 minutes of the 60th day of the Legislative Session. The bill actually establishes a three-member authority to regulate and limit rates hospitals can charge but does not address any costs incurred by hospitals. Interestingly enough, the funding for this bill is borne by the hospitals themselves, thereby increasing their costs. This is reminiscent of medieval times when a condemned person was forced to pay for his own executioner in order to assure a swift and merciful death.

Before this authority has even met, hospital rates have been frozen at the level of February 1, 1983, regardless of any increases in costs for goods and services hospitals may have acquired since that time. In addition, the bill mandates a 12-per cent cap on increases in gross revenue for hospitals. Any funds in excess of this 12 per cent will go to the board itself with no indication as to how these monies are to be spent. Unfortunately, this provision is retroactive to the hospital's last reporting period. This means that if the hospital's fiscal year ended prior to the effective date of this legislation, then the 12-per cent cap could be on 1981 or 1982 revenues.

Many hospitals already may have exceeded those older limits through expanded services and offering improved care. This new legislation does not recognize these exceptions. The money is due *now*. This appears to me to be confiscation, not even an acceptable form of taxation. I am unaware of any other industry in our state which must turn over to a state-appointed bureaucracy a percentage of its gross revenue, not its profits.

Perhaps, if this legislation sets a precedent, the State Highway Department and the Department of Motor Vehicles will set the same sort of cap on the revenues of the automobile dealers in our state and, by confiscating their money, could obtain the funding to fix the roads. In this example, one thing is for sure: there would be a lot fewer automobiles using those roads.

The bill also allows the rate regulators to have jurisdiction over the professional charges of a hospital-based physician under contract to a hospital. I do not feel that it would be advantageous to our attempts to attract top-flight radiologists, anesthesiologists, pathologists and emergency room physicians to West Virginia to have to inform them that their professional fees will be set in advance by a bureaucratic agency of the state government. Indeed, I wonder if we can retain some of the ones we now have.

As you have probably noticed, I do not like any part of this law. The original intent may have been good, but I feel it was an ill-conceived and politically motivated act which was passed in the closing moments of the session by political pressure, and possibly was poorly understood by a majority of the members of the legislature. I feel it will be detrimental to the quality of medical care of our citizens, as the regulators are given the authority to determine the "quality of care" without any representation or any input from the medical profession.

I fear in the future this will be considered the "Mandolidis decision" for the health care industry in our state. Down the road a few years we will need the same type of bail-out to recover from its effects as industry in our state received this year. Unfortunately, by then it may be far too late for many of our hospitals and physicians.

Harry Shannon MD

Harry Shannon, M. D., *President*
West Virginia State Medical Association

The West Virginia Medical Journal

Editorials

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MORE ON DRGs

Now that we all know all about DRGs (see editorial in April issue of *The Journal*), let's talk about some interesting related issues. Diagnostic Related Groups are the basis for a prospective method of hospital payment for Medicare patients.

We have mentioned that hospital administrators are worried about DRGs. They feel vulnerable to manipulation by staff members who might threaten to run up costs if certain whims and desires are not satisfied. Administrative control over diagnostic enthusiasm is simply not present under our current system. As a matter of fact, it would have been silly for hospital administrators to even think of such control as long as no one questioned payment on the basis of cost.

Things are different now. A cost basis of payment is out because it leads to cost escalation. Prospective payment is in because costs can be budgeted and controlled.

How to get a handle on control of clinical costs is the problem now facing hospital administrators. One method is through utilization review. This has been tried under the old cost basis payment method and found to be of limited use. It will be tried again with more vigor. Another way is somehow to close and exercise more control over medical staffs. Surplus numbers of physicians make this an attractive possibility but altering medical staff bylaws to accomplish it might be difficult.

A sure way to control clinical costs is to have salaried physicians. They make money or they are fired. Have you noticed hospitals in your area employing physicians in newly created positions recently?

There is absolutely no question that the survival of some hospitals is at issue. With or without the wholehearted cooperation of staff physicians, some hospitals are likely to go under as a result of financial pressures brought to bear by DRG prospective pricing.

What if too many hospitals go under? What if three hospitals in Charleston go under, or two in Wheeling or two in Huntington? What would be the medical consequences of such a tragedy? What would be the political consequences?

These are not idle questions. It is being proposed that great risks be taken with our medical care system. Where is the safety net in this high wire act? Where are the life rafts if this ship won't float?

Prospective hospital payment plans using DRGs hold great promise. We do not know whether any plan yet proposed will work. The concept merits testing but not full support. Not yet.

THE PATIENT, OR THE SYSTEM?

We have all heard tales about how this or that health care system is good or bad. The tale is usually followed by an important exception, such as "the system is poor, but my doctor is good." There is no health care system that pleases all, nor will there ever be. The marketplace varies within the political climate, and a framework is produced that tries to serve the common good To do what is best for society as a whole sometimes masquerades as being best for each individual. This leads us to many irreconciliable differences. A system that sacrifices individual needs to more global needs cannot honestly and consistently be represented as best serving my needs or yours.

In such a climate, we try to serve a patient whose individual needs must be paramount. Yet our services must be tempered by the law, the government, third-party payers, hospital facilities and, indeed, the whole social fabric. We commit ourselves to offering the best diagnostic and therapeutic options for an individual patient regardless of time or cost. Then we must modify our suggestions based on some larger perspective. The thread is lost in the

tapestry. Are we fooling ourselves? Are we fooling our patients? Or are we all being fooled?

There is not one system so far and away above all others that all others should cease. Freedom of choice is a fine idea, but let it be made clear that a commitment to one or another health care system is not necessarily a commitment to better health care for every individual.

That one individual will still depend upon other individuals for proper care. The health care system serves the people. We as physicians serve the patient. — *Stephen H. Franklin, M.D., in the Delaware Medical Journal.*

Our Readers Speak

Points In Article Questioned

I have read with special interest the article by Parkinson and Nerhood ["Speeial Article: Emergency Maternal Transfer: An Ounce of Prevention for West Virginia Newborns," by Rosalind Parkinson, M. A.; and Robert C. Nerhood, M. D., *The Journal*, January, 1983, Page 9] and find several points to be either inaccurate or possibly inappropriately interpreted.

1. Based on the illustration presented in the artiele, the present aeeelerated (if any) decline in infant mortality began in the 60s, long before the organized effort toward regionalization. It is not clear in the literature when or why this trend began but it is clear that the increased infant survival is related to multiple factors of which the eollaborative efforts to regionalize perinatal care is only a single factor. The statement, "Much of the increased infant survival is associated with collaborative efforts to regionalize perinatal intensive care on a statewide basis," certainly should be referenced since it states an opinion.

2. The authors have grouped *all* hospitals other than CAMC [Charleston Area Medical Center], Cabell-Huntington and West Virginia University into a single category called Community Hospitals. This effectively places all hospitals having between one and 1,600 births in the same category and therefore introduces an initial bias in any statistical analysis.

For instanee [in the following Table], neonatal mortality for the Raleigh General Hospital in Beckley for the years 1978-82 for infants weighing under 2,000 grams was 179.2/1,000 live births. This figure is equal to, if not better than, that given for "perinatal centers." During this period, there was only one maternal transport, and that in a patient with severe congenital heart disease and a term gestation.

Table

Weight	*# births*	*Fetal deaths*	*Neonatal deaths*	*NND rate*
500-999	63	26	16	432/1,000
1,000-1,499	42	12	11	366/1,000
1,500-1,999	128	11	6	51.2/1,000
Total	233	49	33	179/1,000

Further analysis of the above Table shows that nine of the 16 neonatal deaths in the 500-999 range weighed under 750 grams.

3. The use of the 500 to 1,999-gram category probably is too all inclusive. These should be separated into smaller weight eategories. In 1978, 43 per cent of neonatal deaths in West Virginia oeeurred in pregnancies ending before the 28th week of gestation; 43.2 per cent weighed less than 1,000 grams; and nine per cent, less than 500 grams.

4. The decision to undertake maternal transport may be influenced in a negative direction by prior knowledge of anomaly incompatible with life (54/311 in 1978), by weight or gestational age considerations or anticipated labor-delivery intervals. Crude mortality rates include these factors as a built-in bias.

5. The authors should use either neonatal mortality rates or infant mortality rates in a consistent manner.

Maternal transport is an important eonsideration; more important, however, is the continuing upgrading of the larger "community hospitals" to tertiary levels. This is occurring and will, I think, predictably lower the number of maternal and neonatal transports in the future. The "expertise distanee" between *major medical centers* and quality "community hospitals" has narrowed appreeiably in the last decade, and will continue to do so in the future.

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Research Methods Defended

(*Editor's Note: The following is in response to the above letter.*)

We welcome this opportunity to address several important points included in Doetor Pulliam's comments about our study which suggests reduced mortality among small infants is associated with maternal transfer to perinatal centers.

Many hospitals of all sizes in West Virginia report data which show very low mortality among small infants. In some cases, the mortality rates are far below those for perinatal centers. However, for purposes of analysis it is necessary either to examine a large population of infants or take a statistical sample of this group. This exercise is important since rates calculated from small numbers may be due more to chance than to any other identifiable feature. In our study we used an entire population of infants, and units of analysis were large enough for us to note trends and/or associations with eonfidence.

Another important principle of investigation is the careful justification of categories used in the analysis. In our study we chose to compare infant outcomes between perinatal centers—hospitals staffed and equipped to provide infant intensive care—and all other hospitals. Subdivision of the latter group requires justification. Should hospitals with equipment for infant intensive care be examined separately? Should hospitals with associated pediatricians become a separate category?

Doctor Pulliam suggests that size of a hospital's birth volume may be a good parameter. Our analyses in separate studies of infant mortality by size of hospital birth volume in West Virginia do not point to any clear relationship between these variables. In fact, contrary to Doctor Pulliam's implied assumption that bigger hospitals may have better outcomes, our preliminary results suggest that there may be a *negative* association between size of hospital birth volume and low infant mortality.

Full discussion of many of these issues may be found in a recent article published after the acceptance of our manuscript for publication in the *Journal;* a full review of the extensive previous literature on this subject also is included: Paneth N *et al.*: Newborn intensive eare and neonatal mortality in low-birth-weight infants: A population study. *N Engl J Med* 1982; 307(3):149.

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GENERAL NEWS

FMG Educational Commission Head Keynote Speaker

An authority in international medicine who has held top posts at Johns Hopkins University School of Medicine and in Beirut, Lebanon, will be the keynote speaker for the State Medical Association's 116th Annual Meeting.

Dr. Samuel P. Asper, President of the Educational Commission for Foreign Medical Graduates (ECFMG) in Philadelphia, will deliver the Thomas L. Harris address during opening exercises Friday morning, August 26, it was announced by the Program Committee. His topic will be "Strengths and Weaknesses of the U. S. Role in International Medicine."

The convention will be held August 25-27 at the Greenbrier in White Sulphur Springs.

The ECFMG provides information to FMGs about entry into graduate medical education and health-care systems, and evaluates FMGs' qualifications. The Commission, a non-profit organization established in 1956, also gathers, maintains, and disseminates data regarding FMGs.

The Annual Meeting will open with a preconvention session of the Association's Council and the first session of the House of Delegates on Thursday morning and afternoon, August 25; and end with the second and final House session and reception for new Association officers on Saturday morning and afternoon.

Dean of American University of Beirut

Doctor Asper, from 1973 until 1978, was Dean of the School of Medicine of the American University of Beirut (AUB), one of three overseas schools of medicine affiliated with Johns Hopkins, and Chief of Staff of the American University Hospital. Under his direction, the AUB Medical Center held together during the Lebanese civil strife of 1975-76, caring for 8,500 casualties. For his work in providing treatment for the American community in Lebanon, Doctor Asper received a citation in 1976 from the then Secretary of State Henry A. Kissinger.

Doctor Asper, a native of Texas, has held his present ECFMG post since June, 1982, and has been Professor of Medicine at Johns Hopkins since 1960. He was graduated from Baylor University, and received his M. D. degree in 1940 from Johns Hopkins. Following an internship in medicine in the Johns Hopkins Hospital, he began a fellowship in endocrinology at Harvard. This was interrupted by World War II, during which he served in the Harvard Medical Unit in Europe for nearly four years.

Following the war, Doctor Asper resumed his fellowship for two years at Harvard, then returned to Johns Hopkins. In endocrinology, his work related to both clinical and research aspects of the thyroid gland. As Associate Dean from 1957 to 1968, he guided postdoctoral activities at Johns Hopkins, including the international program, and coordinated Johns Hopkins' affiliation with the American University of Beirut.

ACP President

From 1967 to 1970, Doctor Asper, successively, was Vice President, President Elect and President of the American College of Physicians,

Samuel P. Asper, M. D.

and, from 1970 to 1973, was Vice President for Medical Affairs of the Johns Hopkins Hospital.

The 9 o'clock opening exercises Friday morning will precede the first general scientific session, a "Symposium on Sexually Transmitted Diseases" featuring four speakers. As announced previously, two of the speakers will be Drs. Lee P. Van Voris, Associate Professor of Medicine at Marshall University, whose topic will be "Non-Luetic, Non-Gonococcal Venereal Diseases," and George J. Pazin, Associate Professor of Medicine, University of Pittsburgh, "Transmissible Diseases of the Gay Patient."

Other subjects for the Friday morning session will be syphillis and gonococcal infections; and sexual mores in the 1980s.

The second and final general scientific session will be held Saturday morning and, also as announced previously, will be a "Symposium on Cardiovascular Diseases." Individual subjects will include new developments in the management of cardiac arrhythmias; an update relative to cardiovascular surgery; and the management of congestive heart failure.

In addition to the general sessions, the Annual Meeting agenda will include breakfast, luncheon and other programs arranged by specialty societies and sections, many of which also will provide scientific discussions.

The specialty group meetings will be held in large measure on Friday, with a few to be set for Saturday morning, preceding the second general session and at noon.

Doctor Adkins to be Installed

At the final House session on Saturday afternoon, Carl R. Adkins, M. D., of Fayetteville will be installed as the Association's 1983-84 President to succeed Harry Shannon, M. D., of Parkersburg.

The Auxiliary to the State Medical Association, with Mrs. Richard S. Kerr of Morgantown the current President, as usual will hold its meeting in conjunction with that of the Association.

Members of the 1983 Program Committee are David Z. Morgan, M. D., Morgantown, Chairman; Doctor Adkins; Jean P. Cavender, M. D., Charleston; Michael J. Lewis, M. D., St. Marys; Kenneth Scher, M. D., Huntington, and Roland J. Weisser, Jr., M. D., Morgantown.

Additional information concerning speakers and other convention details will be provided in upcoming issues of *The Journal.*

Continuing Education Activities

Here are the continuing medical education activities listed primarily by the West Virginia University School of Medicine for part of 1983, as compiled by Dr. Robert L. Smith, Assistant Dean for Continuing Education, and J. Zeb Wright, Ph. D., Coordinator, Continuing Education, Department of Community Medicine, Charleston Division. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of The Journal.)

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the Morgantown, Charleston and Wheeling campuses. Further information about these may be obtained from: Division of Continuing Education, WVU Medical Center, 3110 MacCorkle Avenue, S. E., Charleston 25304; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 2000 Eoff Street, Wheeling 26003.

May 7, Charleston, Outpatient Infectious Diseases

May 20-21, Morgantown, Health Officers Conference

June 3-4, Morgantown, Anesthesia Update '83

June 4, Charleston, 10th Annual Wildwater Conference — Medical & Surgical Update

June 11, Morgantown, Interventional Radiology

Regularly Scheduled Continuing Education Outreach Programs from WVU Medical Center/ Charleston Division

Buckhannon, St. Joseph's Hospital, first-floor cafeteria, 3rd Thursday, 7-9 P. M. — May 19, "Evaluation of Infertility and Frequent Spontaneous Abortions," Bruce L. Berry, M. D.

June 16, "Sudden Infant Death Syndrome," David Myerberg, M. D.

Cabin Creek, Cabin Creek Medical Center, Dawes, 2nd Wednesday, 8-10 A. M. — May 11, "Hypertension Update," Steven Grubb, M. D.

Gassaway, Braxton Co. Memorial Hospital, 1st Wednesday, 7-9 P. M. — May 4, "Management of Trauma in the Small Hospital Setting and During Transport," Paul Derboven, M. D.

June 1, "Common Blood Disorders," Steven Jubelirer, M. D.

July 6, "The Pharmacology of Hypertension Management," Stephen Grubb, M. D.

Aug. 3, "Diagnosis of Pulmonary Disorders," Dominic Gaziano, M. D.

Madison, 2nd floor, Lick Creek Social Services Bldg., 2nd Tuesday, 7-9 P. M. — May 10, "Common Dermatological Problems," Stephen K. Milroy, M. D.

June 14, "Recently Recognized Sexually — Transmitted Diseases," Thomas W. Mou, M. D.

July 12, "Approach to the Peripheral Vascular Patient," Ali F. AbuRahma, M. D.

Oak Hill, Oak Hill High School (Oyler Exit, N 19) 4th Tuesday, 7-9 P. M. — May 24, "Pharmacology & Clinical Use of Calcium & Beta Blockers," Robert Hoy, Pharm. D.

Welch, Stevens Clinic Hospital, 3rd Wednesday, 12 Noon-2 P. M. — May 18, "Gastro-Intestinal Bleeding," Warren Point, M. D.

Whitesville, Raleigh-Boone Medical Center, 4th Wednesday, 11 A. M.-1 P. M. — May 25, "Lower Gastro-Intestinal Disorders," Warren Point, M. D.

Williamson, Appalachian Power Auditorium, 1st Thursday, 6:30-8:30 P. M. — May 5, "Update Thyroid Dysfunction," Richard Kleinmann, M. D.

Doctor Point ACP Governor

Dr. Warren Point of Charleston recently was elected a Governor of the American College of Physicians. Doctor Point, an internist and Chairman of the Department of Medicine, West Virginia University Medical Center, Charleston Division, will hold his post as Governor of West Virginia for four years.

A native of Charleston, he was graduated from WVU, and received his M. D. degree in 1945 from Harvard Medical School.

Wildwater Medical-Surgical Conference June 3-4

Colonic and breast cancer will be the subjects of the day for the 10th annual Wildwater Conference: Medical and Surgical Update, on Saturday, June 4, in Charleston.

The meeting site will be the West Virginia University Medical Center Education Building, with the program to begin at 7:30 A. M. and end at 3 P. M. Offered on Friday is a wildwater trip on New River from Thurmond to Fayette Station (15 miles).

Sponsors are WVU Charleston Division and Charleston Area Medical Center.

The Saturday morning program on "The Colonic Cancer Problem" will include five speakers, who will join for a panel discussion at the conclusion. The speakers and topics will be "Chemotherapy-CA of the Colon"—Steven J. Jubelirer, M. D., Assistant Professor of Medicine, WVU Charleston Division; "Colonoscopy" —Brittain McJunkin, M. D., Clinical Assistant Professor of Medicine, WVU Charleston Division: "Radiological Diagnosis-CA of the Colon"—Clinton A. Briley, M. D., Clinical Assistant Professor of Radiology, WVU Charleston Division;

Boston, Wisconsin Speakers

"Surgical Treatment of CA of the Colon"—Claude Welch, M. D., Senior Surgeon, Massachusetts General Hospital, Boston, and Clinical Professor of Surgery, Emeritus, Harvard Medical School; and "Polyps and Cancer"—Alvin L. Watne, M. D., Professor and Chairman, WVU Department of Surgery, Morgantown.

Speakers for the afternoon session, "Breast Cancer in 1983," will be William L. Donegan, M. D., Professor of Surgery, University of Wisconsin, on "New Approaches to Breast Cancer:" Edward Wheatley, M. D., Clinical Assistant Professor of Radiology, WVU Charleston Division, "Mammography in the Diagnosis of CA of the Breast:" and Doctor Jubelirer, "Chemotherapy-CA of the Breast." A panel discussion will follow.

The program is approved for five credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

Registration by May 27 is requested for the scientific program. The fee, including lunch, for physicians is $40 ($45 after May 27). For additional information, telephone (304) 347-1242.

The fee for the wildwater trip is $59. For additional information or reservations, call (304) 348-5511. Reservations are limited.

Keep Insanity Defense, Says Doctor Bateman's Group

The insanity defense in criminal trials should not be abandoned, Dr. Mildred M. Bateman and other members of a National Mental Health Association commission say in a report released recently in Washington, D. C.

Doctor Bateman, Chairman of the Marshall University School of Medicine Psychiatry Department, said the group also opposes adoption of the "guilty but mentally ill" verdict. (The West Virginia Senate in its recently completed session killed a bill which would have created this verdict in the state.)

"One of the myths surrounding the insanity defense is that it causes major problems for law enforcement and the criminal justice system," Doctor Bateman said. "Actually, it's successfully used infrequently enough that it causes few practical problems, but it does have a very important moral role. We found that in a society that has as its core a concern for the individual, the plea is not only an appropriate part of the criminal code, but a necessary one as well."

She said that the "not guilty by reason of insanity" plea is used much less often than many people believe. "Testimony before our commission indicated that of the 32,000 adult defendants represented by the New Jersey public defender last year, 52 entered insanity pleas — and only 15 were successful," she said. "In Virginia, fewer than one per cent of the felony cases involve the insanity defense."

Disposition of Those Acquitted

The group also recommended that legislatures adopt laws concerning the disposition of persons acquitted under the insanity defense.

"We think that a lot of the public's fear and concern about the insanity defense is not so much that a person can be acquitted because he's proven mentally ill, but what happens afterward," Doctor Bateman said. "Is he returned to society as a free agent, or are there appropriate custody and treatment programs available?

"The responsibility of the court does not end with the finding of not guilty by reason of insanity," she said. "We recommend that the states develop — and adequately fund — systems for providing treatment."

She added that such programs reduce repeat crimes. "Testimony we heard indicated that 76 per cent of patients released from Maryland's treatment and conditional release program were not re-arrested in the four-year study period," she said.

The nine-member commission, led by former U. S. Senator Birch Bayh, was formed to study issues raised following the trial of presidential assailant John Hinckley.

Review A Book

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication.

Basic and Clinical Pharmacology, by Bertram G. Katzung, M. D., Ph.D. 815 pages. Price $23.50. Lange Medical Publications, Los Altos, California 94022. 1982.

Living With Herpes, by Deborah P. Langston, M. D. 198 pages. Price $7.95. Doubleday & Company, Inc., 245 Park Avenue, New York, New York 10167. 1983.

Current Medical Diagnosis and Treatment, 1983, edited by Marcus A. Krupp, M. D.; and Milton J. Chatton, M. D. 1130 pages. Price $24. Lange Medical Publications, Los Altos, California 94022. 1983.

General Ophthalmology, 10th Edition, by Daniel Vaughan, M. D.; and Taylor Asbury, M. D. 407 pages. Price $17. Lange Medical Publications, Los Altos, California 94022. 1983.

Group Elects MU Doctor

Dr. David K. Heydinger of the Marshall University School of Medicine was elected President-Elect of the National Rural Primary Care Association at its recent annual meeting in Kansas City.

He currently serves on the group's board.

Doctor Heydinger, who joined the faculty in 1978, is Associate Dean for Academic Affairs and Chairman of the Department of Family and Community Health.

Residency Locations Announced For Marshall Graduates

Seventeen members of the Marshall University School of Medicine's 1983 graduating class of 36 students will remain in West Virginia for their residencies, Dean Robert W. Coon, M. D., has announced.

Nine of the 17 will remain in Huntington, and the others will go to Wheeling, Morgantown, Clarksburg and Charleston, he said.

Remaining in Huntington are Frederick D. Adams and Richard M. Hatfield, both of Logan; Denise E. Clay Allen of Gilbert; Karen N. Dansby of Ashland, Kentucky; Durwood F. Gandee of Weirton; William D. Given of Strange Creek; John L. Hahn of Wardensville; Darrell W. Jordan of Ona, and Lou Gene Kingery of Kenova.

Other graduating seniors remaining in West Virginia and their residency locations are: David A. Brosius of Sutton and Kelly M. Pitsenbarger of Franklin, United Hospital Center, Clarksburg; Samuel R. Davis of Marlinton and Wayne E. Groux of Wheeling, Ohio Valley General, Wheeling;

Ronald DeAndrade, Jr., of Buckhannon, West Virginia University Hospital; Daniel B. Prudich and Reginald J. McClung, both of Charleston, and Mark K. Stephens of Madison, Charleston Area Medical Center.

Other students and their residency locations are: Gerald G. Blackwell of Gauley Bridge, Ohio State University Hospitals; Leo R. Boggs, Jr., of Danville, Hershey (Pennsylvania) Medical Center; Craig L. Bookout of Philippi, Self Memorial Hospital, South Carolina; Mary B. Butcher of Glenville, Riverside Methodist Hospital, Ohio; James W. Endicott of Kermit, North Carolina Baptist;

Albert J. Exner of Huntington, University of Maryland; Bijan J. Goodarzi of Elkins, Akron (Ohio) City Hospital; Garrie J. Haas of Charleston, Ohio State University Hospital; James D. Hoffman of Huntington, University Health Center Hospitals, Pittsburgh; Harry J. Magee of Charleston, University of California, Los Angeles; Larry D. Mann of Princeton, Ohio State University Hospitals;

Bradley R. Martin of Princeton, Akron City Hospital; William E. Muth of Morgantown, University Hospitals, Madison, Wisconsin; Daniel B. Ray of Ironton, Ohio, Aultman/Timken Hospitals, Ohio; Hobart K. Richey of Wellsburg, University of Southern Florida-affiliated hospitals;

William S. Sheils, Jr., of Huntington, Ohio State University Hospitals; Carol M. Spencer of Huntington, Maine Medical Center; Sandra L. Tabor of Switzer, Ohio State University Hospitals, and Samuel D. Wellman of Kenova, University of Louisville-affiliated hospitals.

Majority Of WVU Graduates Choose Primary Care

Primary care specialties are the residency choice of more than half the West Virginia University School of Medicine class of 1983.

Of the 80 seniors who will receive their M. D. degrees on May 15, 46, or 57.5 per cent, will take all or part of their postgraduate training in either internal medicine, family practice or pediatrics. Internal medicine is the choice of 22, 14 opted for family practice, and six chose pediatrics.

Another three will combine pediatrics and medicine residencies, and one will combine medicine with psychiatry.

Exactly half of this year's class will remain in West Virginia, including 21 at WVU, 16 at the Charleston Area Medical Center (CAMC), one at Ohio Valley Medical Center in Wheeling, and two in Wheeling Hospital's Family Practice Program.

Primary care areas also are the choice of more than 67 per cent of those staying in the state. Thirteen will enter family practice programs, 12 chose internal medicine, and two will enter pediatric residencies.

Other residency choices among seniors are: surgery, 12; emergency medicine, 5; ophthalmology and radiology, 4 each; psychiatry, 3; anesthesia, 2, and obstetrics/gynecology, orthopedics and pathology, one each.

One will enter a flexible residency program and choose a specialty after the first year.

Class of '83

Members of the class of 1983, their hometowns and destinations are:

Arif A. Alidina, Lewisburg, University of Pittsburgh Health Center Hospitals; Robert D. Allara, Iaeger, WVU Department of Ophthalmology; Michael T. Angotti, Clarksburg, Medical College of Virginia, Richmond; Harold G. Ashcraft, Mannington, WVU Department of

Medicine: William C. Bird, Matoaka, WVU Department of Pathology: Wayne R. Brearly, Morgantown, Mercy Hospital, Pittsburgh: John A. Burdette, St. Albans, CAMC: Kim B. Carey, Weirton, WVU Department of Family Practice: Janet E. Cogar, Flatwoods, University of Kentucky Hospital, Lexington: Brad R. Cohen, Charleston, CAMC;

Steven W. Collins, Glenville, North Carolina Baptist Hospitals, Winston-Salem: Anne C. Cutlip, Webster Springs, WVU Department of Family Practice: William B. Dennison, Huntington, University of Kentucky Hospital, Lexington: Mark T. Domenick, Morgantown, WVU Department of Family Practice: Joseph D. Dye, Huntsville, Alabama, Andrews Air Force Base Hospital: Karen M. Fanucci, Morgantown, Mount Auburn (Massachusetts) Hospital: Patrick R. Felice, Morgantown, Saint Francis Hospital, Connecticut: Linda S. Gray, Wheeling, University of Massachusetts Hospitals: Mark K. Greathouse, New Manchester, Mercy Hospital, Pittsburgh: Karen M. Gross, Martinsburg, WVU Department of Family Practice;

Lynn H. Harris, Charleston, WVU Department of Radiology: Jeffrey P. Hogg, Beckley, University of Pittsburgh Health Center Hospitals: Gavin N. Hogue, Scott Depot, CAMC: Thomas L. Hurt, Morgantown, University of California at San Diego: Richard J. Jackson, Martinsburg, WVU Department of Surgery: Jocelyn L. James, Morgantown, University of Texas Health Science Center, San Antonio: David T. Kirk, Scott Depot, Hunterdon Medical Center, Flemington, New Jersey: Vincent P. Kolanko, Weirton, WVU Departments of Medicine and Pediatrics:

Susan L. Koletar, Pittsburgh, CAMC: Robert W. Koss, Fairmont, WVU Department of Anesthesia: John S. Koval, Weirton, CAMC: Jane A. Kurucz, Morgantown, Ochsner Foundation Hospital, New Orleans: Lester Labus, Barboursville, and John A. Lane, Charleston, CAMC: Robert A. Leadbetter, Morgantown, University of Virginia Hospital, Charlottesville: Carolyn L. Looney, Morgantown, Quillen-Dishun College of Medicine, Johnson City, Tennessee: John A. Mardones, Clarksburg, Rush-Presbyterian-St. Luke's Medical Center, Chicago: David C. Martin, Charleston, St. Louis University Hospitals: Scott A. McNamara, Wheeling, Georgetown University Hospital, Washington, D. C.: Loren M. Meyer, Lutheran General Hospital, Chicago: Aileen H. Miller, Chapel Hill, North Carolina, Moses H. Cone Memorial Hospital,

(Continued on page xxiii)

New Patient Record Law Effective In June

Here is the 1983 state legislative enactment, proposed by the State Medical Association, setting up provisions under which patients may obtain copies of summaries of their records from health care providers, including physicians. The new act will be effective June 10.

"**ARTICLE 29** (in Chapter 16 of the Code).

HEALTH CARE RECORDS.

"§16-29-1. Copies of health care records to be furnished to patients.

Any licensed, certified or registered health care provider so licensed, certified or registered under the laws of this state shall, upon the written request of a patient, his authorized agent or authorized representative within a reasonable time, furnish a copy or summary of the patient's record to the patient, his authorized agent or authorized representative subject to the following exceptions:

(a) In the case of a patient receiving treatment for psychiatric or psychological problems, a summary of the record shall be made available to the patient, his authorized agent or authorized representative following termination of the treatment program.

(b) Nothing in this article shall be construed to require a health care provider responsible for diagnosis, treatment or administering health care services in the case of minors for birth control, prenatal care, drug rehabilitation or related services, or venereal disease according to any provision of the code, to release patient records of such diagnosis, treatment or provision of health care as aforesaid to a parent or guardian, without prior written consent therefore from the patient, nor shall anything in this article be construed to apply to persons regulated under the provisions of chapter eighteen (education) of this code or the rules and regulations established thereunder.

(c) The furnishing of a copy or summary of the reports of x-ray examinations, electrocardiograms and other diagnostic procedures shall be deemed to comply with the provisions of this article.

(d) For purposes of this article, "patient record" does not include a provider's office notes.

(e) The provisions of this article may be enforced by a patient, authorized agent or authorized representative, and any health care provider found to be in violation of this article

shall pay any attorney fees and costs, including court costs incurred in the course of such enforcement.

"§16-29-2. Reasonable expenses to be reimbursed.

The provider shall be reimbursed by the person requesting in writing a copy of such records at the time of delivery for all reasonable expenses incurred in complying with this article."

Council Action Embraces Variety of Subjects

Concern regarding the potential impact of a new state law setting up a hospital rate review and rate setting mechanism was expressed by the State Medical Association's Executive Committee and Council during April 9-10 meetings in Charleston.

Major provisions of the 1983 enactment were outlined in a *Journal* story in April, and Harry Shannon, M. D., the Association's President, has devoted his monthly page to that issue this month (see page 104).

Council has instructed the Association staff and legal counsel to monitor closely implementation of the new statute, to the extent of studying the advisability of entering into any litigation which might develop to test the law's various components.

In other action on April 10, the Council:

—Charged the Executive Committee and Committee on Professional Liability to meet with representatives of CNA and McDonough Caperton Shepherd to fashion a more comprehensive loss control effort in line with the Association-endorsed professional liability insurance program.

Health Director Reports

—Heard State Health Director L. Clark Hansbarger, M. D., report that each county health department soon will have in hand extensive new statistical and other data that will be used in planning future activity and working with county commissions on budgets.

—Received a progress report on continued planning toward a state headquarters building in information provided by John Markey, M. D., in his role as President of West Virginia State Medical Association Properties, Inc.

—Reviewed other 1983 legislative activity, including enactment of a new statute relative to patient records which is printed in its entirety on page 112 of this issue of *The Journal*.

—Elected Carl J. Roncaglione, M. D., to the West Virginia Medical Political Action Committee (WESPAC) Board as the nucleus member from the Third Congressional District to replace Joseph T. Skaggs, M. D., who resigned.

Bylaws Amendments

—Approved for introduction in the Association's House of Delegates in August bylaws amendments to make a Committee on Audit and Budget a standing committee.

—Authorized introduction in the American Medical Association House of Delegates in June, in Chicago, resolutions to add state medical association/society presidents as members of the House; and calling on the AMA to withdraw all support from the Joint Commission on Accreditation of Hospitals in view of proposed JCAH standards revisions eliminating the term "medical staff" in lieu of an "organized staff." A draft of the revisions also would, among other things, eliminate references to physician responsibility for the general condition of hospitalized patients; and eliminate references to physician supervision of treatment provided by limited licensed practitioners.

—Voted to ask Thomas G. Potterfield, M. D., of Lewisburg to represent the Medical Association on a School Health Advisory Council to work with state education and health departments toward a comprehensive school health program in West Virginia.

Honorary Memberships

—Elected to honorary membership, in the wake of appropriate local society action, the following: Drs. Eugene E. Hutton, Jr., Elkins; Albert C. Esposito, Huntington; Edward Jackson, St. Albans; Marion F. Jarrett, Charleston; George R. Mullins, Logan; Charles S. Flynn, Bluefield; Lawrence J. Pace, Princeton; Robert T. Bandi and James C. Hazlett, both of Wheeling; Robert M. Biddle, Little Hocking, Ohio, and Jack J. Stark, Belpre, Ohio (both Parkersburg Academy members); and Grover C. Hedrick, Jr., Paul E. Vaughan, Everett B. Wray and John W. Whitlock, all of Beckley.

—Elected to retired membership Drs. J. Dennis Kugel, Charleston; James L. Deadwyler, Fairmont; and Andrew K. Butler, Herman Rubin, William J. Steger and Robert O. Strauch, all of Wheeling.

Handicapped Newborn Rules Challenged By AMA

The American Medical Association will file an amicus brief in a suit challenging new regulations in the treatment of severely handicapped newborns. The friend-of-the-court brief will be in support of a suit filed in March by the American Academy of Pediatrics and the National Association of Children's Hospitals.

The suit seeks to block enforcement of rules requiring all hospital maternity wards, obstetrical wards, and nurseries to post notices warning that failure to feed and care for handicapped infants is prohibited by law.

The notices encourage anyone who thinks an infant is being denied food or "customary medical care" to call a hot line at the U. S. Department of Health and Human Services, or to telephone the state's child protection agency.

"The purpose of a rule like this goes beyond the decision between physicians and families concerning a handicapped infant," said AMA Executive Vice President James H. Sammons, M. D. "Once a government agency has interjected itself into the practice of one medical specialty, that kind of interference could be expanded to other specialties. Then each of us — physicians and patients — would have our decisions subjected to review by strangers making arbitrary and perhaps capricious judgments about our own life and death events," he said.

The AMA will object to the unusually brief public comment period before the rules went into effect. The AMA also is opposed to a provision that allows HHS investigators to have 24-hour access to facilities if necessary to protect the life or health of a handicapped infant.

The HHS rule was developed in response to the death last year of a six-day-old boy afflicted with Down's syndrome. "Baby Doe" died in Bloomington, Indiana, after his parents requested that food and medical treatment be withheld.

Doctor Traubert Appointed

Dr. John W. Traubert of Morgantown recently was appointed to the Mead Johnson Awards Committee of the American Academy of Family Physicians. The committee was established to administer an annual grant financing a year of graduate training in an approved family practice residency. Doctor Traubert is Professor and Chairman, Department of Family Practice, West Virginia University School of Medicine.

Medical Meetings

May 2-6—Am. Psychiatric Assoc., New York City.

May 4-7—WV Chapter, Am. College of Surgeons, White Sulphur Springs.

May 6-8—Southern Medical Assoc. Regional Postgraduate Conference, Lexington, KY.

May 8-12—Am. College of Obstetricians & Gynecologists, Atlanta.

May 13-14—Topics in Cardiovascular Diseases (Am. Heart Assoc.), Baltimore.

May 19-20—National Conference, Breast Cancer (Am. Cancer Society), Boston.

May 20-22—Am. Counseling Assoc., Morgantown.

May 26-28—Am. Assoc. of Genitourinary Surgeons, White Sulphur Springs.

June 5-9—Am. Society of Colon & Rectal Surgeons, Boston.

June 7-10—Society of Nuclear Medicine, St. Louis.

June 17-18—Society for Vascular Surgery, San Francisco.

June 19-23—Annual Meeting of AMA House, Chicago.

June 22-25—Am. College of Surgeons, Eastsound, WA.

June 23-26—Am. Medical Women's Assoc., Minneapolis.

Aug. 25-27—116th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

Sept. 29-Oct. 2—Am. Society of Internal Medicine, San Francisco.

Oct. 16-21—Am. College of Surgeons, Atlanta.

Oct. 22-27—Am. Academy of Pediatrics, San Francisco.

Oct. 23-27—Am. College of Chest Physicians, Chicago.

Oct. 23-29—Am. College of Gastroenterology, Los Angeles.

Nov. 6-9—Scientific Assembly, Southern Medical Assoc., Baltimore.

Nov. 30-Dec. 1—Am. College of Chemosurgery, Chicago.

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WVU Medical Center
–News–

Compiled from material furnished by the Medical Center News Service, Morgantown, W. Va.

ENT Laboratory Arm Of CDC In AIDS Cause Quest

Acquired immune deficiency syndrome (AIDS) is a modern medical mystery.

Scientists know that its greatest incidence is among male homosexuals, Haitians and abusers of intravenously injected drugs. The syndrome also has affected some hemophiliacs, leading researchers to believe its transmission may be linked to blood products.

AIDS directly results from an imbalance in subsets of certain white blood cells which brings about a suppression of the immune response.

What changes this delicate balance? Is it some bacterium, virus or combination of pathogens? Or are many recurrent infections from, or re-exposures to, some ever present, disease-producing agent the answer?

As a regional laboratory for the Centers for Disease Control (CDC) in Atlanta, WVU's ENT Diagnostic Laboratory is playing a part in adding to the body of knowledge concerning this phenomenon.

Virology and Immunology

The laboratory specializes in virology and immunology. Its Director, James E. McClung, M.S., took much of his graduate study at the CDC with special emphasis on the Epstein-Barr virus, one of the herpes family.

"CDC is interested in looking at the individual with a slightly lowered cell-mediated immune response who may be borderline for AIDS," McClung said. "In that way they hope to come up with an etiological agent."

"Probably the causative agent has come and gone in the active AIDS cases who have opportunistic infections or Kaposi's sarcoma."

Kaposi's sarcoma, a rare type of skin cancer, is found in 28 per cent of AIDS patients. Nearly half of them fall victim to pneumocystis carinii pneumonia, a protozoa infection.

But these diseases are believed to be the results of impaired immunity, not its cause.

The instigator may be an ultravirus or a new virus, McClung said.

"The current theory, however, is that AIDS individuals have repeated bouts of infection with cytomegalovirus, herpes simplex or possibly Epstein-Barr, all members of the herpes family," he explained.

CMV Prime Suspect

"CMV is probably the prime suspect right now. Most individuals have very minor symptoms with it. They get over it and have no further problems. CMV causes a problem with organ transplant patients and cancer patients who are immunosuppressed.

"When the herpes viruses are active, the infection itself causes a suppression of the immune response. It may be that AIDS victims have so many recurrent infections or re-exposure to the viruses that their immune systems just finally break down."

Hepatitis B, which also is found frequently among homosexuals and drug users, and known to be transmitted in blood products, also is suspected as a contributing factor.

McClung said the diagnosis for AIDS was made by the determination of the ratio of helper T-cells to suppressor T-cells in a blood sample. These white blood cells are involved in the immune response—the helper cells fighting off infection by aiding in the production of antibodies, and the suppressor cells stopping the response.

"In AIDS, the problem is a lower number of helper cells but an increased number of suppressor cells," he said.

Foundation Appointment

Jack E. Riggs, M. D., Assistant Professor of Neurology, has been appointed to the medical advisory board of the national Myesthenia Gravis Foundation. Doctor Riggs is a medical graduate of the University of Rochester, and joined the WVU faculty in 1981.

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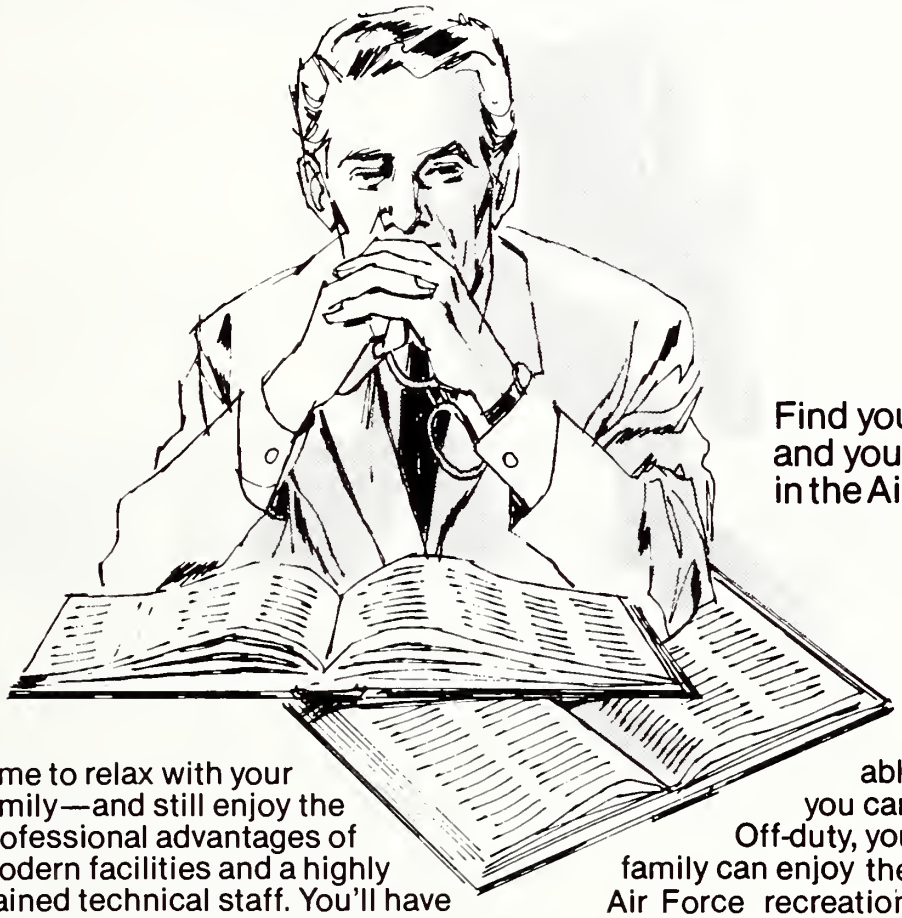

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Third-Party News, Views and Program Concerns

Prospective Payment Approved, 'Heavy Impact' Expected

Attached to the Social Security Act of 1983 recently approved by Congress and signed by President Reagan are measures that will have heavy impact on the nation's health care system, the American Medical Association has commented. The bill contains provisions to hold down the cost of Medicare payments to hospitals through a prospective payment plan based on diagnosis-related groups (DRGs). Hospitals will be paid on the basis of 467 DRGs regardless of the costs actually incurred in treating patients.

Under the bill approved by Congress:

—DRG payments will be phased in over three years, beginning with the hospital's first cost reporting period after October 1, 1983. In the first year, 25 per cent of the payment will be based on DRG rates, and 75 per cent on the hospital's cost base. The percentage of the payment based on DRGs gradually will increase until it reaches 100 per cent in the fourth year.

—In the first year, the DRG portion of the payment will be a regional rate. A rural and an urban rate will be calculated for each of nine regions. In the second and third years, the DRG portion will be a blend of national and regional rates and, by the fourth year, the 18 regional rates will give way to two national rates—one urban, one rural.

1984-85 Rates

—Rates in 1984 and 1985 will be adjusted by the market-basket index of hospital costs plus one per cent, but they would be reduced to the extent this resulted in payments exceeding those that would have applied under the Tax Equity and Fiscal Responsibility Act targets.

—Beginning in 1986, the increase factor will be determined by the Secretary of Health and Human Services and reviewed by a 15-member commission appointed by the Office of Technology Assessment. The commission is to include representatives of a wide range of groups, including new technology and treatments, and is to recommend changes in the recalibration of the DRG classifications.

—Direct medical education expense will continue to be paid on a cost basis, and the current Section 223 adjustment for indirect medical education expenses will be doubled in the DRG system.

Capital Costs

—Capital costs incurred before the system took effect will continue to be reimbursed on a reasonable cost basis until October 1, 1986. New capital costs may or may not be paid on a reasonable cost basis. States will be required to have Section 1122 review systems, and Medicare reimbursement for new capital costs will be conditioned on 1122 approval. The maximum threshold the state may use for requiring an 1122 review is increased from $100,000 to $600,000.

—Return on equity for proprietary hospitals will be reduced.

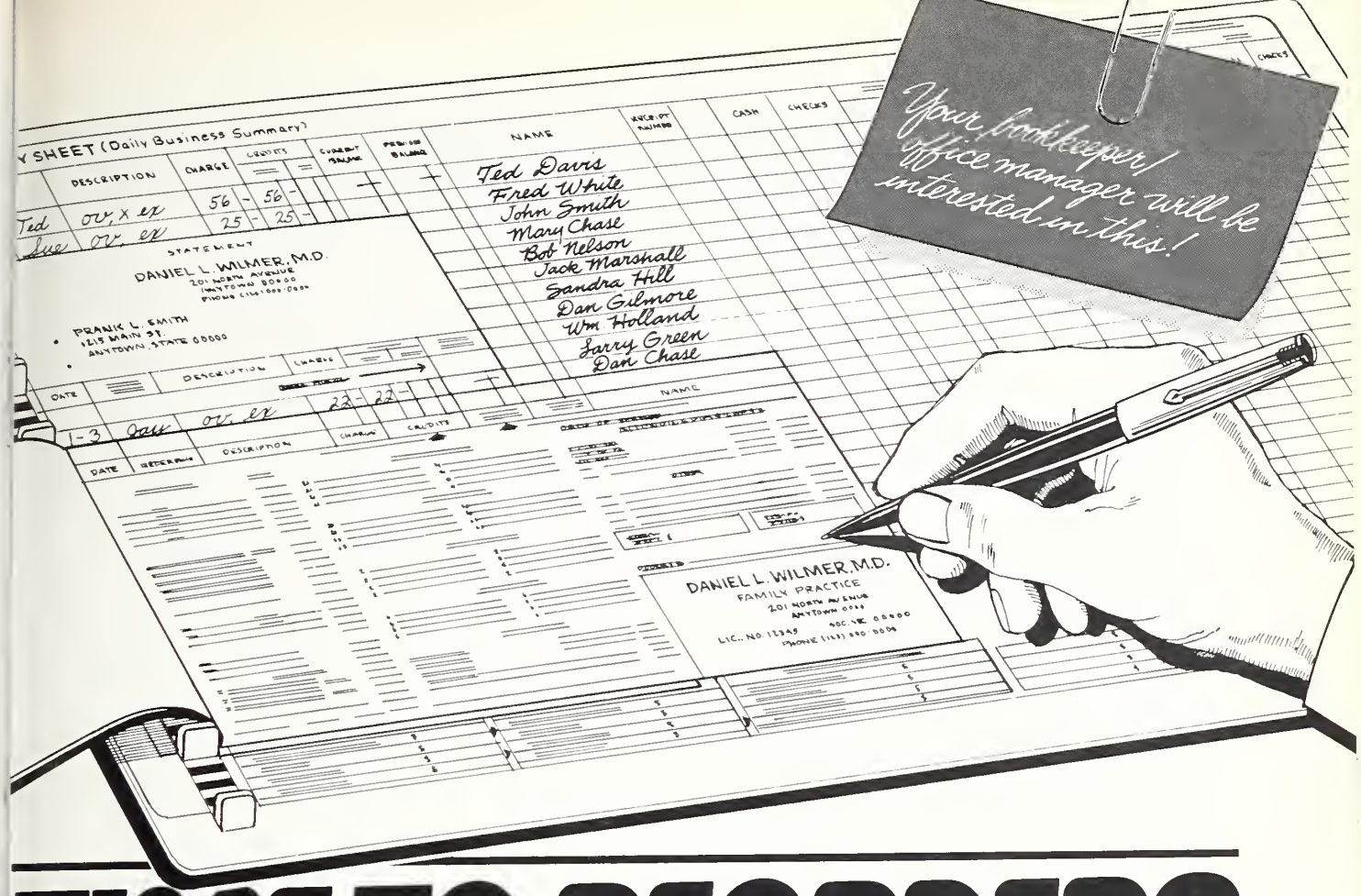
—Certain types of institutions will be exempt from the DRG system.

—From now until October 1, 1983, hospitals are required to contract with a Professional Review Organization (PRO) to monitor utilization if there is a PRO in the area. After October 1, the hospital is required to contract with a PRO, and cannot be paid by Medicare if a PRO review is not performed. Intermediaries will be allowed to participate in the PRO program by October 1, 1984, at the latest.

Physician Charges Eyed

—State payment systems covering all payors will be encouraged through waivers if the state system will cost Medicare no more than the federal DRG system.

—HHS is to report in 1985 on the "advisability and feasibility" of applying DRGs to physician charges for hospital services, and is to recommend legislation to apply DRGs to physicians.



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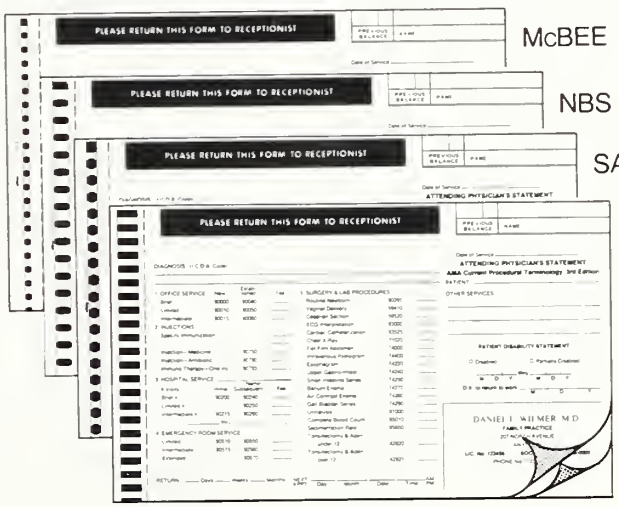

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Obituaries

JAMES H. THORNBURY, M. D.

Dr. James H. Thornbury of Belle (Kanawha County) died on March 19 in a Charleston hospital. He was 74.

Doctor Thornbury was a retired physician for the DuPont plant in Belle. He was Belle's first mayor.

Born in Genoa (Wayne County), he formerly practiced in Man (Logan County) before going to Belle 43 years ago. He was a former physician for the University of Charleston.

Doctor Thornbury was graduated from West Virginia University, and received his M. D. degree in 1936 from Jefferson Medical College. He interned at Newark (New Jersey) Memorial Hospital.

Doctor Thornbury was a member of the Kanawha Medical Society, West Virginia State Medical Association and American Medical Association.

Survivors include the widow; three sons, James Thornbury of Webster, New York; Robert Thornbury of St. Petersburg, Florida; and David Thornbury of Lexington, Kentucky; a brother, Lawrence Thornbury of Asbury (Greenbrier County), and three sisters, Mrs. Frances Prochilo of Massapequa, New York; Mrs. Nancy Cairoof of Hampstead, New Hampshire, and Mrs. Romaine Melara of Lewisburg.

* * *

THOMAS V. SHIELS, M. D.

Dr. Thomas V. Shiels of South Charleston died on March 21 at his home there. He was 77.

Doctor Shiels, an internist, was a retired physician for the Union Carbide Corporation in South Charleston.

Born in Craven, Saskatchewan, Canada, he received both his undergraduate and M. D. (1939) degrees from the University of Illinois. He interned at Swedish Covenant Hospital, and took his residency at the Louisville Veterans Administration Medical Center.

Doctor Shiels also had practiced for short periods in Fayetteville, North Carolina, and Williamson.

Survivors include the widow; a stepson, Paul Epperly of Ellenboro; a sister, Mrs. Marjorie Thibodeau of Victoria, British Columbia, Canada; and two brothers, Warren Shiels of Standard, California, and Leonard Shiels of Craven, Saskatchewan.

He was an honorary member of the Kanawha Medical Society, West Virginia State Medical Association and American Medical Association.

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MEDICAL STAFF

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Charles C. Weise, M. D.	925-2159
Thomas S. Knapp, M. D.	925-3554
Pablo M. Pauig, M. D.	343-8843
Ralph S. Smith, M. D.	925-0349
Lee L. Neilan, M. D.	925-0349
Edmund C. Settle, Jr., M. D.	925-6914
Gina Puzzuoli, M. D.	925-6914
John P. MacCallum, M. D.	925-6966

CHILD PSYCHIATRY

Henrietta L. Marquis, M. D.	925-3160
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County Societies

FAYETTE

The Fayette County Medical Society met on March 2 at Montgomery General Hospital.

The guest speaker was Dr. Kenneth M. Harman of Charleston, whose topic was "Total Parenteral Nutrition."—S. S. Maducdoc, Jr., M. D., Secretary/Treasurer.

* * *

JEFFERSON

Dr. Rebecca Garrett of Hagerstown, Maryland, was the guest speaker for the meeting of the Jefferson County Medical Society on March 2. Her topic was "Arthritis."

New officers were elected.—William S. Miller, M. D., Secretary/Treasurer.

* * *

McDOWELL

The McDowell County Medical Society met on March 9 in Welch at the Stevens Clinic Hospital.

The guest speaker was Dr. Robert Lapin, Clinical Assistant Professor of Medicine, Infectious Diseases, Albert Einstein Medical College, New York City. His subject was "Update on the Management of Medical and Surgical Infections."—Muthusami Kuppusami, M. D., Acting Secretary.

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WVU GRADS—*Continued from page 112*

Greensboro, North Carolina; Frederick E. Moore, Charleston, Aultman Hospital, Canton, Ohio;

Larry W. Moreland, Mount Storm, WVU Department of Medicine; Michael S. Solomon, Parkersburg, CAMC; Alan L. Myers, Philippi, WVU Department of Behavioral Medicine and Psychiatry; Patton V. Nickell, Buckhannon, WVU Departments of Medicine and Behavioral Medicine and Psychiatry; Ross S. Oliver, Wheeling, CAMC; Lawrence N. Payne, Parkersburg, Akron (Ohio) City Hospital; Debra G. Perina, Harpers Ferry, Richland Memorial Hospital, Columbia, South Carolina; Stuart W. Point, Charleston, CAMC; Stephen R. Powell, Scott Depot, WVU Department of Ophthalmology; Lee A. Pyles, Fairmont, University of Minnesota Hospitals; Janis E. Reed, Morgantown, St. Francis General Hospital, Pittsburgh; Gary J. Renaldo, Fairmont, Medical College of Virginia; David M. Ritchie, Ravenswood, CAMC; Charles L. Rolfe, Morgantown, Ohio Valley Medical Center, Wheeling; William D. Rose, Geisinger Medical Center, Charlton Heights, Pennsylvania;

David B. Rymer, Parkersburg, WVU Department of Anesthesia; Ralph A. Sellers, Fairmont, University of Mississippi Hospital; Henry L. Setliff, Shady Spring, University of South Florida Medical Center, Tampa; Robert N. Shobe, Burlington, Allegheny General Hospital, Pittsburgh; Sydney G. Short, Morgantown, North Carolina Baptist Hospital; Cynthia C. Sims, Colbers; William R. Sims, Huntington, and Daniel L. Smith, Sissonville, CAMC; Gregory D. Snodgrass, Gauley Bridge, and Natalie C. Snodgrass, Wheeling, Ohio State University Hospitals; Thomas J. Soltis, Huntington, WVU Department of Medicine; Jack R. Steel, Morgantown, WVU Department of Orthopedics; Phillip R. Stevens, Bridgeport, WVU Department of Surgery;

Jane E. Thrush, Morgantown, University of Pittsburgh Health Center Hospitals; Vincent C. Traynelis, Morgantown, WVU Department of Surgery; Michael B. Voorhees, Martinsburg, Wheeling Hospital; Charles B. Voss, Wheeling, University of Hawaii Hospitals; James W. Wallace, St. Albans, CAMC; Mark R. Weiser, Parkersburg, Tripler Medical Center, Hawaii; Daniel W. Wilson, St. Marys, Wheeling Hospital; Cynthia A. Winger, Huntington, CAMC; Sanjay S. Yadav, St. Albans, Veterans Administration Medical Center, Long Beach, California; and John M. Zambos, Beckley, WVU Department of Surgery.

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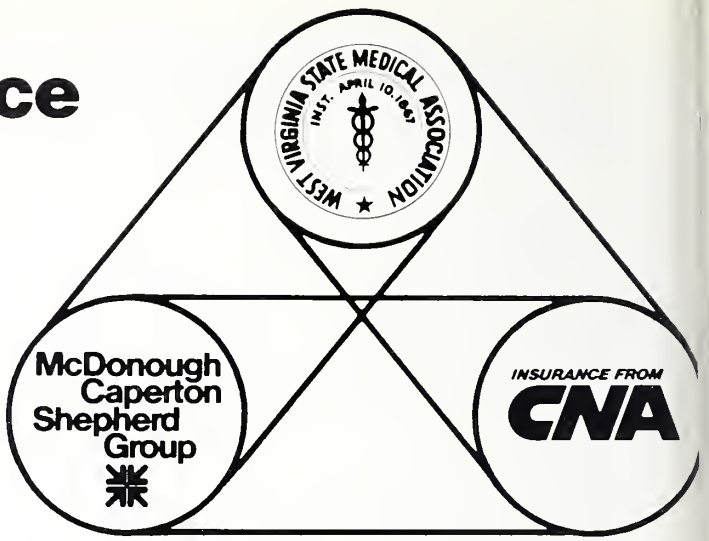

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The West Virginia Medical Journal

Vol. 79, No. 6 June, 1983

Hospices Are Developing In West Virginia: What Physicians Need To Know

PETER C. RAICH, M. D.
Professor of Medicine and Chief, Section of Hematology Oncology, West Virginia University School of Medicine, Morgantown

RICHARD JOHN C. PEARSON, M. B., M.P.H.
Professor and Chairman, Department of Community Medicine, WVU School of Medicine

RICHARD M. IAMMARINO, M. D.
Professor of Pathology and Director, Clinical Laboratories, WVU Medical Center; and President, Morgantown Hospice, Inc.

Hospice programs have grown rapidly within the United States during the past decade. West Virginia presently has five active hospice programs, and four in various stages of activation. These programs are designed to provide care by health professionals and volunteers to incurably ill patients. Control of debilitating and demoralizing symptoms allows patients to remain within their homes and family circle. Physicians can contribute significantly to the care and understanding of such patients during the end stages of their illness.

Hospices came to be developed in response to a perceived problem: the process of dying was being mismanaged. Either too little was being done for the patient because the disease process (usually cancer) was too far advanced for treatment to be effective, and there was a failure to appreciate that even when the disease was incurable the patient still needed to be cared for; or too much was done in a stubborn, last-ditch, no-holds-barred battle against the disease even when the prognosis was hopeless. That the problem was real has become obvious since approximately 600 hospices are active or are being developed in the United States today. This is all the more remarkable in that there were none 12 years ago.

In West Virginia today there are five hospices active: in Martinsburg, Wheeling, Charleston, Huntington and Beckley; and there are four more developing in Morgantown, Clarksburg, Parkersburg and Putnam County (see Appendix).

History of Modern Hospice

While there is a long history of institutions, usually church-related, where all kinds of sick people have been lovingly cared for, the rapid development of the hospice concept specifically for the terminally ill in the United States in recent years can be traced to two sources: the development of a research and teaching hospice in London, England, and the work of Dr. Elizabeth Kubler-Ross. Dr. Cicely Saunders, in a London hospital after the end of World War II, had been nursing a dying man who was an exile from his country and alone, and needed help with a whole range of personal matters before he could feel comfortable to die with his affairs in order. They discussed the shortcomings of the hospital services, and he left her funds to establish a better way of caring for the terminally ill.[1] She spent the next 20 years becoming prepared to open her hospice to put into practice their ideas, and act as a demonstration of what could be done.

A year or two after this hospice opened, Doctor Kubler-Ross' book, *On Death and Dying*, was published.[2] This book, which has become

a classic, deals with a series of interviews Doctor Kubler-Ross carried out in a dying patient population at the University of Chicago. In the book, Doctor Kubler-Ross has characterized what she calls the five stages of dying, namely, "denial," "anger," "bargaining," "depression," and "acceptance."

Content of a Hospice Program

Hospice care does not relate to a place but a concept of dealing with dying patients with dignity, openness and compassion to help them and their families reach "acceptance." Although hospice programs take many forms, the most common one relates to a home care program administered by the small nuclear staff which coordinates services including skilled nursing care, care by nurse's aides, medical social workers, ministers, and bereavement counseling services following the death of the patient.

Hospice care is, of necessity, time-intensive. It takes many people several hours to establish a close relationship with the patients and their families. For this reason, hospice programs have had to rely heavily on trained volunteers for provision of many of the services where discrete, medically defined skills were not necessary. The characteristics of a hospice program are itemized in Table 1.[3]

Recent Federal Legislation

Federal legislation was passed as a part of the Tax Equity and Fiscal Responsibility Act, 1982, that develops a mechanism for Medicare to pay for hospice care. However, the regulations that are being promulgated to implement this legislation in November, 1983, have features that will make it financially impossible for any hospice in West Virginia, or in a rural area elsewhere in the country, to be able to participate. The regulations require the hospice: to provide directly and substantially all of the nursing care (by an RN), the medical social services, and physician and counseling (bereavement, dietary and nutritional) services; to retain supervision and management responsibility, including central clinical records on all its patients; and to be liable for hospital bills for patients who incur bills greater than Medicare will pay.

TABLE 1

Characteristics of a Hospice Program of Care

1. Coordinated home care, with inpatient beds under a central, autonomous hospice administration.
2. Control of symptoms (physical, sociological, psychological, and spiritual).
3. Physician-directed services.
4. Provision of care by an interdisciplinary team.
5. Services available on a 24-hour-a-day, 7-day-a-week basis with emphasis on availability of medical and nursing skills.
6. Patient and family regarded as a unit of care.
7. Bereavement follow-up.
8. Use of volunteers as an integral part of the interdisciplinary team.
9. Structured personnel support and communication systems.
10. Patients accepted to the program on the basis of health needs, not ability to pay.

None of the West Virginia programs has the financial resources to handle these requirements. Hospice programs in West Virginia will therefore have to develop independently, and rely, at least to some extent, upon volunteer services and charitable contributions.

Do's and Don'ts for Physicians

Following are some do's and don'ts for physicians:

1. Do get involved with the hospice movement. If there is a hospice in your community, see if there is any way that you can help.

2. Do refer patients for their care.

3. Don't be afraid that hospice personnel are not professional. Typically, individuals who work with a hospice are dedicated, and have had training to fulfill their roles. These roles do not replace physician services but amplify and complement them.

4. Do be honest with your patients. If you believe that they are terminal, then the message needs to get across either to the patient or a family member so that realistic family planning can take place. and support from hospice can be had.

5. Don't withdraw just because you cannot care or even palliate. You can still help with symptom and pain control.

Symptom Control

Outlined below are two areas of symptom control.

I. *Control of Pain in Cancer*

Because of the diverse causes of cancer-related pain, a number of treatment modalities may be useful and worthy of consideration in such patients (Table 2). Below we have selected and discussed in greater detail some of the commonly used agents.

TABLE 2

General Principles of Cancer Pain Management*

Cause of Pain	*Primary Treatment*	*Secondary Treatment*	*To Consider*
VISCERAL: involvement of abdominal or pelvic organs	Analgesics	Low-dose steroids	Celiac axis block for abdominal pain. Intrathecal block for pelvic pain
BONE PAIN: Direct spread distant metastases	1. Palliative radiotherapy 2. Non-steroidal, anti-inflammatory drugs 3. Immobilization: Cervical collar, pinning	Analgesics	Nerve block. Low-dose steroids
SOFT TISSUE INFILTRATION	Analgesics	Low-dose steroids	Nerve block
NERVE COMPRESSION	Analgesics	High-dose steroids	Nerve block
SECONDARY INFECTION:	1. Systemic antibiotics including metronidazole if possibility of anaerobes. Local surgery. 2. Systemic antibiotics. Local applications, e.g., Providone, Iodine	Analgesics	Nerve block. Topical local anesthetics
PLEURAL PAIN	Antibiotics if appropriate	Analgesics	Intercostal block
COLIC due to bowel obstruction	Stool softeners. Antispasmodics, e.g., Lomotil	Analgesics	
LYMPHEDEMA	Intermittent positive pressure machine	Analgesics. Jobst sleeve or stocking	High-dose steroids
HEADACHES from raised intracranial pressure	High-dose steroids. Raise head of bed	Avoid opiate analgesics	Diuretics may help
PAIN in paralyzed limb(s)	Physical therapy and regular movement of limb(s)	Non-steroidal anti-inflammatory drugs	Muscle relaxants

*Adapted from Ajemian I, Mount BM[6]

A. Non-narcotic analgesics.

Aspirin and acetaminophen (Tylenol^{R}) are the most commonly used. They are equal in pain-relief activity. Both will decrease fever, but aspirin is a stronger anti-inflammatory agent. Aspirin interferes with platelet function and may lead to gastritis. Pentazocine (Talwin^{R}) and codeine also are active agents for moderate pain, and potentiate the action of aspirin and acetaminophen when combined with these agents. However, pentazocine has bothersome gastrointestinal and central nervous system side-effects. Most of the newer class of non-steroidal, anti-inflammatory agents may be helpful in controlling cancer-related pain, along with other agents, especially in patients with metastases to bone.

B. Narcotic Analgesics

Codeine is an effective oral agent for moderate pain, and often is combined with aspirin and acetaminophen, but may be associated with constipation on prolonged use. For more severe and chronic cancer-related pain, more potent narcotic agents are usually required. The oral administration of morphine sulfate has proven to be especially valuable, and lends itself well to home-care patients.[4] The oral-to-parenteral potency ratio of morphine is 1:3. Although most patients' pain is well controlled on oral doses of 10-30 mg. every four hours, in some patients as much as 100 mg. per dose may be required. Initial drowsiness usually clears after the first three to five days. Morphine sulfate may be made up in simple solution or as a flavored syrup. Morphine may be given in combination with dextroamphetamine five mg. with each morphine dose, except at night, to reduce drowsiness. An antiemetic or oxyphencyclimine (Vistaril^{R}) for anxiety, or amitriptyline (Elavil^{R}) for depression and sleeplessness also may be added. Most hospice programs no longer

advocate the Brompton's cocktail type of mixtures. Methadone is an alternate potent oral narcotic analgesic and has the advantage of a longer drug half-life. The usual dosage is five to 15 mg. every eight to 12 hours. If nausea and vomiting preclude oral analgesics, hydromorphone hydrochloride (Dilaudid[R]) suppositories three mg. every four to six hours, are useful.

C. Pain Control Without Drugs

These measures may help to control milder pain, and when combined with analgesics may be used while waiting for pain medications to take effect or during times of incomplete pain relief. Distraction methods include concentrating on slow, rhythmic breathing and singing or tapping. Relaxation, imagery and skin stimulation with massage, pressure, vibration or menthol gels also may have an adjunctive role in pain control.

II. *Nausea and Vomiting*

Nausea and vomiting can be a major problem in cancer patients receiving cytotoxic chemotherapy or radiation therapy, but also may be secondary to the malignancy itself or its complications.[5] Control of these symptoms frequently can be achieved with the proper selection and trial of a variety of effective anti-nausea agents. These are usually available in oral, parenteral or suppository preparations. The following have been found to be especially useful in cancer patients.

A. Phenothiazines — inhibit stimulation of the chemo-receptor trigger zone.

Prochlorperazine (Compazine[R]) five to 10 mg. q. four hours.

Chlorpromazine (Thorazine[R]) 10 to 25 mg. q. four hours.

Triethylperazine (Torecan[R]) 10 mg. tab. or supp. q. four hours.

B. Antihistamines — diminish vestibular input, mildly sedating.

Benadryl 25-50 mg. q.i.d.

C. Halperidol (Haldol[R]) one to two mg. q. eight hours.

Metoclopramide (Reglan[R]) — used IV for cis-platinum-induced nausea.

D. Corticosteroids — may be combined with effervescent phosphates.

Prednisone at one mg/kg. dose is treatment of choice for hypercalcemia.

Dexamethasone (Decardron[R]) for vomiting secondary to raised intracranial pressure four mg. q.i.d.

E. Tetrahydrocannabinol (THC) approved for use only with chemotherapy at present.

F. Additional measures may be beneficial in patients with troublesome nausea and vomiting:

1. Identify and eliminate cause where possible.
2. Vomiting is often tolerated in the the absence of nausea.
3. Frequent oral hygiene, especially after each emesis and prior to meals.
4. Eliminate repulsive odors and sights.
5. Bowel regulation.
6. Frequent small bland feedings when desired, including carbonated beverages.
7. Antiemetics one hour before meals.

By the judicious use of these and other methods of symptom control the quality of life may be improved dramatically in such patients. Much can be done to help patients and their families during the terminal phase of illness. The hospice program merely allows for the proper blending of the skills of health professionals with the dedication of volunteers.

> "Surely though the recovery of the patient be the grand aim of their (physicians') profession, yet where that cannot be attained, they should try to disarm death of some of its terrors, and if they cannot make him quit his prey, and the life must be lost, they may still prevail to have it taken away in the most merciful manner."
>
> William Heberden, 1710-1801

Editor's Note: Here are the generic drugs and trade names (in parentheses) to which reference is made in this manuscript: acetaminophen (Tylenol); aspirin; amitriptyline hydrochloride (Elavil); chlorpromazine (Thorazine); codeine sulfate; dexamethasone (Decadron); dextroamphetamine (Obetrol); diphenhydramine hydrochloride (Benadryl); haloperidol (Haldol); hydromorphine hydrochloride (Dilaudid); metoclopramide (Reglan); morphine sulfate; oxyphencyclimine (Vistaril); pentazocine (Talwin); prednisone; prochlorperazine (Compazine); tetrahydrocannabinol; and triethylperazine (Torecan).

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Appendix

Contact Persons for Hospices in West Virginia

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Hospice of Putnam County
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Teens' Newborns Not Always Less Healthy

ALTHOUGH teenage pregnancy is considered a major social problem in the United States, the newborns of teenage mothers are not necessarily less healthy than those of older mothers, according to two University of Michigan researchers.

Newborns and infants of teenage mothers, although often weighing less than offspring of mothers in their 20s, actually score higher on some tests of early physical and mental development, write Stanley M. Garn, Ph.D., and Audrey S. Petzold, from the University's Center for Human Growth and Development, in a recent issue of *American Journal of Diseases of Children.*

Surgical Treatment Of The Subclavian 'Steal' Syndrome

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Various procedures have been proposed for the treatment of subclavian "steal" syndrome, none of which has been uniformly accepted by vascular surgeons. The authors analyze their experiences with this problem with emphasis on axillary-to-axillary bypass for the surgical correction of this disease.

Of the patients with symptomatic subclavian "steal" syndrome who were corrected surgically at Charleston Area Medical Center between August, 1978, and February, 1982, 20 were corrected either by axillary-to-axillary artery bypass (12 patients) or carotid-to-subclavian bypass (eight patients). All other cases were excluded.

Ten of the 12 axillary-to-axillary bypass grafts and two of the carotid-subclavian bypasses (12 of 20 cases) were done by our group.

Analysis of 12 Patients

Ages range from 44 to 66 years. There were five males and seven females.

Ten of our 12 patients had clinical symptoms of left subclavian "steal" (Figure 1). Two of these had left arm claudication. Of the remaining two, one had right subclavian "steal" and the other had both right subclavian "steal" and right carotid "steal" secondary to innominate artery occlusion (Figure 2). All of these patients had an arm Doppler pressure difference of > 15 mm. Hg and a weaker pulse on the diseased side. All patients are analyzed in the Table.

Follow-up period ranged from three to 40 months.

Axillary-to-Axillary Technique

Two transverse incisions are made over the delto-pectoral grooves. The incision is deepened to expose the axillary artery, axillary vein and brachial plexus. The second portion of the axillary artery is isolated. An eight-mm Gortex graft is sutured in place in end-to-side fashion. The graft is placed underneath the pectoralis major and then through a tunnel which is made

Figure 1a. A patient with complete occlusion of the left subclavian artery.

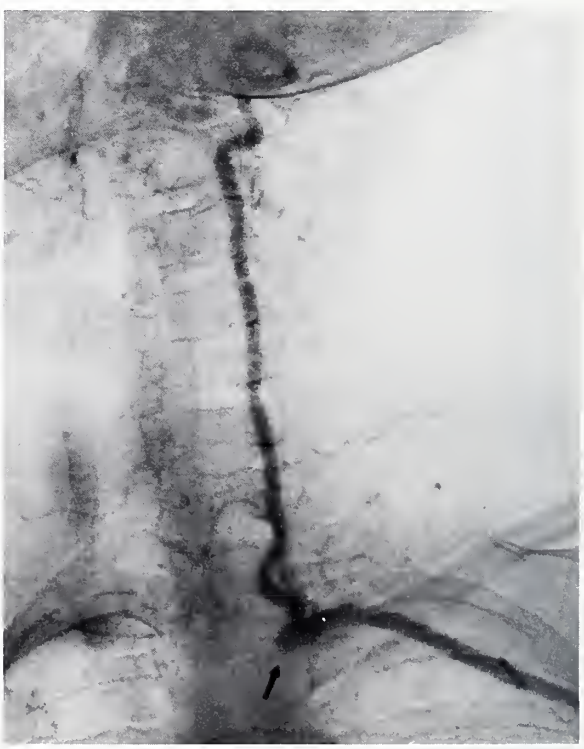


Figure 1b. The same patient with left subclavian "steal."

in the presternal subcutaneous tissue to the contralateral axilla. The contralateral end of the graft also is placed under the pectoralis major. The distal end of the graft is then sutured to the other axillary artery in end-to-side fashion (Figures 3a and 3b).

TABLE

Twelve Patients with Subclavian "Steal" Syndrome

Case	*Age*	*Sex*	*Radiological Findings*	*Operation*	*Followup in months*	*Complications*	*Patency*
1	62	M	Left subclavian stenosis with vertebral "steal"	Axillary-axillary bypass	24	None	Patent
2	64	F	"	"	23	"	"
3	50	F	"	Left carotid subclavian bypass	26	"	"
4	56	F	"	Axillary-axillary bypass	40	"	"
5	54	M	"	"	28	"	"
6	44	F	"	Left carotid subclavian bypass	32	"	"
7	62	M	Rt. subclavian stenosis with vertebral "steal"	Axillary-axillary bypass	27	Parasthesia of hand—one week	"
8	66	M	Left subclavian stenosis with vertebral "steal"	"	21	None	"
9	59	F	Left subclavian stenosis with vertebral "steal"	Axillary-axillary bypass	18	"	"
10	63	F	"	"	12	"	"
11	53	M	Innominate occlusion with right carotid and subclavian "steal"	"	3	Thrombosis & infection	Removed
12	63	F	Left subclavian stenosis with vertebral "steal"	"	5	None	Patent

Figure 2a. A patient with complete occlusion of the innominate artery which showed right subclavian "steal."

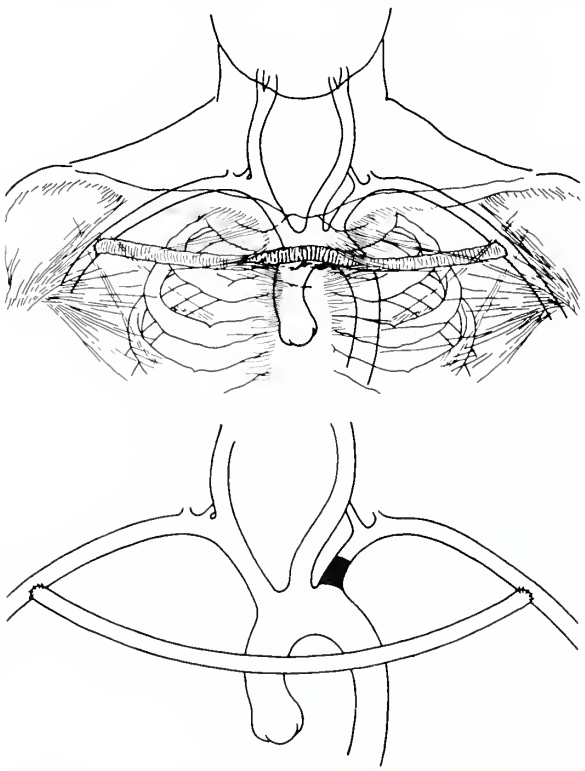
Figure 2b. The same patient with right carotid "steal."

Carotid-to-Subclavian Bypass

A transverse supraclavicular incision is made. The subcutaneous tissue, platysma and clavicular head of the sternocleidomastoid muscle are incised. The sternal head of sternocleidomastoid is retracted medially and the common carotid artery exposed and isolated. The scalenus anticus muscle is transected after isolation of the phrenic nerve. The subclavian artery is exposed and isolated. The graft is sutured to the subclavian artery in end-to-side fashion. The distal end of the graft is then anastomosed to the side of the common carotid artery (end to side) (Figure 4).

Results

The results are summarized in the Table. All symptoms of subclavian "steal" and arm ischemia disappeared. The blood pressure became equal in both arms, and normal pulses were restored. There have been no complications in the two carotid subclavian bypasses (26 and 32 months). One patient who had axillary-to-axillary bypass had thrombosis of the graft three days after surgery. Thromboembolectomy was done but two months later infection necessitated removal of the graft. This case was an emergency axillary-to-axillary bypass for acute occlusion of the innominate artery with right subclavian and carotid "steal" with acute ischemia of the right arm. All other cases (90 per cent) are still patent. Patency rate was determined during five to 40 months' followup. There was no mortality in our series.



Figures 3a (top) and 3b (bottom). Axillary-to-axillary artery bypass graft.

Discussion

This interesting syndrome was first described by the Italian radiologist, Contorni.[1] in 1960. Reivich *et al.*[2] presented the first two cases in American Literature in the *New England Journal of Medicine* (Editorial).[3] In this situation the proximal subclavian artery, usually the left, is occluded while the ipsilateral vertebral artery is patent. There is reversal of flow in the vertebral artery with blood flowing from the brain into the arm distal to the subclavian occlusion via the patent vertebral vessel.

With loss of blood from the brain stem and cerebellum, one may have manifestations of vertebrobasilar insufficiency, e.g., vertigo, headache, bilateral visual disturbances, dysarthria, dysphagia, disorders of equilibrium, impairment of consciousness and drop attacks. There may be monoparesis or paralysis shifting from side to side and involving any or all of the extremities. Sensory defects on both sides of the body, cranial nerve paralysis, and cerebellar signs with ataxia also occur. These symptoms may be precipitated by exercise of the ipsilateral arm.

Detailed serial arteriograms are necessary to establish the diagnosis of this syndrome. Unless symptomatic, patients with this syndrome need not be subjected to surgical correction.

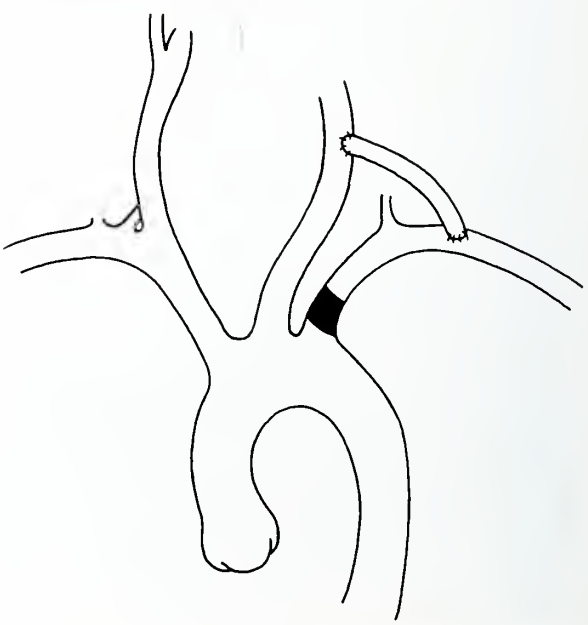


Figure 4. Carotid-to-subclavian bypass graft.

Current Surgical Modalities

Technical procedures have changed considerably during the past decade. In the past, stenoses of the innominate and subclavian arteries were treated by direct endarterectomy or with bypass graft taking origin from the arch of the aorta. Although blood flow restoration was quite satisfactory, it soon became obvious that mortality and morbidity for these procedures were quite high (20-per cent mortality).[4]

Consequently, new methods were devised for treating these lesions, resulting in the use of extrathoracic approaches and cervical bypass procedures almost routinely. These operations are simpler to perform, carry a low mortality and morbidity, and are quite satisfactory.

1. *Carotid-to-Subclavian Bypass*: Its technique was described earlier (Figure 4). This procedure was described first by North[5] and associates, and popularized by Diethrich.[6]

Advantages:

A. Extrathoracic approach — much less morbidity and mortality.

B. The long-term patency rate is excellent.

Diethrich *et al.* reported 125 patients with carotid subclavian bypasses followed from nine months to 14 years with a 4.8 mortality. Only two grafts failed (one thrombosis and one infection).

Disadvantages:

A. Possible vascular "steal" from the ipsilateral carotid artery.[7,8] However, this point has been controversial; supporters of the procedure have pointed out both clinically and experimentally that there would be no "steal" with this kind of procedure.[5,6]

B. The necessity of clamping the donor carotid artery while the proximal anastomosis is being performed.

C. Possible cerebral embolization from the graft suture line.

D. Stenosis of the carotid graft by kinking with neck motion.

E. Rarely, injury to phrenic nerve or thoracic duct.

F. The subclavian artery is usually a friable, thin-walled vessel, and may present technical difficulty in graft anastomosis. Blaisdell[9] reported a four-per cent incidence of central nervous system complications after carotid subclavian bypass.

There was a total of eight cases of carotid subclavian bypass done at Charleston Area Medical Center in the last three years. All these are still patent.

2. *Axillary-to-Axillary Artery Bypass*: In 1971, Myers *et al.*[10] first reported the use of the axillo-axillary bypass in revascularizing an upper extremity in a very-poor-risk patient. Since then, the reported experiences (not including our 12) total 38 cases:

Source	*Year*	*Cases*
Myers *et al.*[10]	1971	2
Mozersky *et al.*[11]	1972	3
Jacobson *et al.*[12]	1973	1
Dardik & Dardik[13]	1974	2
Leveen *et al.*[14]	1974	1
Snider *et al.*[15]	1974	6
Lamis *et al.*[16]	1976	9
Myers *et al.*[17]	1979	14
AbuRahma *et al.*	Present Series	12*

*These cases were done to both good- and high-risk patients.

The results of all the reported experiences have been excellent with good restoration of antegrade flow in the recipient vessels and without evidence of a "steal" from the donor vessel.

Advantages:

A. Extrathoracic.

B. Simple.

C. Does not require carotid manipulation.

D. Does not require subclavian dissection (*i.e.*, will avoid injury to phrenic nerve, thoracic duct, etc.)

E. Easy to palpate and follow.

Disadvantages:

A. Possible compression of the graft against the sternum: this is very rare.

B. Needs careful dissection of the axillary artery to avoid injury to the brachial plexus. (That is why we select the second portion of the axillary artery as the donor site.)

A total of 12 cases were treated at Charleston Area Medical Center, 10 of these by our group. There was no mortality or morbidity except in one case where thrombosis and infection occurred (three to 40 months' followup).

Subclavian artery transposition or implantation into the common carotid artery could be done instead of the carotid-to-subclavian bypass.

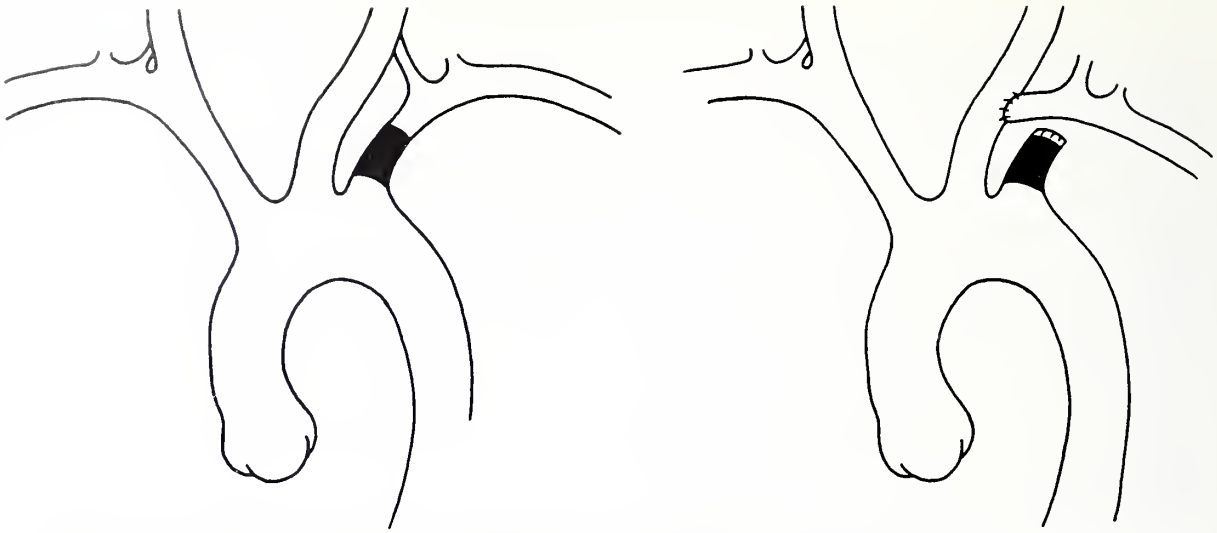


Figure 5. Case of complete occlusion of left subclavian artery which was corrected by subclavian artery transposition or implantation into the common carotid artery.

The only difference here is that instead of using a graft, the distal end of the subclavian distal to the occlusion is anastomosed to the common carotid artery (Figure 5). It has the same advantages and disadvantages of carotid subclavian bypass.

Subclavian-to-subclavian artery bypass also can be done. In this procedure, both subclavian arteries are exposed, as described previously, by supraclavicular incisions (Figure 6). This procedure was described briefly by Blaisdell *et al.*[9] and Ehrenfeld *et al.*[18] in 1968 and 1969. Finkelstein *et al.* [19] reported the first 15 patients who had this procedure in 1972. He reported no mortality or morbidity in all 15 patients who were followed from six months to four years.

Summary

Various procedures have been proposed for the correction of symptomatic subclavian "steal" syndrome. Twenty cases of these were treated at Charleston Area Medical Center in the last four years: 12 with axillary-to-axillary artery bypass, and eight with carotid subclavian bypass. There was no mortality. One patient had thrombosis and infection of the graft, while the remaining 19 had patent grafts (three to 40 months' follow-up). All patients' symptoms and signs were relieved.

Axillary-to-axillary bypass currently is our procedure of choice for the correction of symptomatic subclavian "steal" syndrome. It appears to be the simplest to perform with the least potential complications.

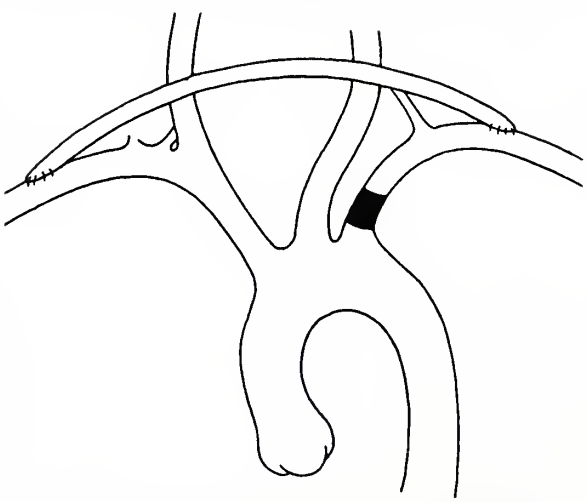


Figure 6. Subclavian-to-subclavian artery bypass.

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Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing the most commonly known trade-name drug of that designation. In addition, a listing of all generic drugs mentioned in the article, with their trade-name equivalents, should appear at the end of the article.

A short abstract summarizing the manuscript should be included. This should be typed in double space on a separate page.

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Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for reproduction should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. Cost of printing black and white photos in excess of 4 will be billed to author, and no more than 25 references will be published free of charge to the author. A legend should be provided for each illustration and, preferably, attached to it.

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HEALTH SCIENCES LIBRARY

Medical Grand Rounds

From the West Virginia University Medical Center

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Ketotic Hypoglycemia

Discussant:
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Medical Student III

Although its etiology is still unknown, ketotic hypoglycemia remains the most common cause of childhood hypoglycemia, representing 65 per cent of the cases. This disorder affects children predominantly between the ages of one and 1.5 years, and remits spontaneously with increasing age, usually before eight or nine. These children are symptom-free between episodes.

Clinically, one should suspect ketotic hypoglycemia in any child older than one year with central nervous system symptoms, decreased blood sugar, and ketonuria in the absence of hepatomegaly. Ketotic hypoglycemia can be distinguished from hyperinsulinism with a glucagon challenge test performed after provocation of symptomatic hypoglycemia by fasting or administration of a high-fat, ketogenic diet.

Treatment is relatively simple: administration of a high-carbohydrate, high-protein diet with extra feeds at bedtime, in conjunction with an early breakfast. This usually precludes the need for drug therapy. For acute hypoglycemic episodes, oral or intravenous glucose is quite effective.

Long-term prognosis is good. The risk of mental retardation and intelligence impairment is proportional to the degree of control and frequency of hypoglycemic episodes.

ALTHOUGH its etiology is still unknown, ketotic hypoglycemia remains the most common cause of childhood hypoglycemia, accounting for 65 per cent of the cases. This disorder affects predominantly children between the ages of one and 1.5 years, and remits spontaneously with increasing age, usually before eight or nine. These children are symptom-free between hypoglycemic episodes.

History

Ross and Joseph first noted the combination of convulsions, hypoglycemia and ketonuria in 1924. In 1964, Colle and Ulstrom performed a classic study on childhood hypoglycemia, and are quoted extensively throughout the subsequent and current literature. They studied children with recurrent episodes of symptomatic hypoglycemia associated with ketonuria which occurred after a period of low carbohydrate intake. The hypoglycemia exhibited a minimal or no response to glucagon.

Clinical Picture

Clinically, a previously active, healthy child gradually develops lethargy, somnolence, hypotonia and, in extreme cases, coma and seizures after a period of fasting or low carbohydrate intake. Vomiting is usually associated with hypoglycemia. Blood glucose is usually 50 mg/dl, and can be as low as 18-20 mg/dl. The symptoms respond dramatically to oral glucose or, if the patient is unresponsive, to intravenous glucose.

These children generally have a history of being small-for-gestational-age infants, and of prematurity. Physical examination is significant for the absence of hepatomegaly.

In summary, the Colle and Ulstrom study illustrated the following characteristics of the disorder.[1]

1) The patients appear to be in good health prior to attacks.

2) The first attack rarely occurs before the age of 18 months.

3) Attacks occur after a period of food deprivation.

4) Ketonuria is associated with the hypoglycemia.

5) Response to glucose is prompt.

6) Fasting blood glucose levels are normal between attacks. There is no hypoglycemia after glucose loading. When the patient receives a normal diet, glycogen stores are present after a 12-hour fast, and are discharged in response to glucagon and/or epinephrine.

7) Most children are normal or near normal in intelligence: attacks tend to decrease in frequency as they become older.

8) The children are below the fifteenth percentile in both height and weight but are more retarded in weight than in height.

Differential Diagnosis

The differential diagnosis of childhood hypoglycemia involves a number of complex disorders which can usually be ruled out by history, physical examination and laboratory data. Explaining each of these cases is beyond the scope of this paper and can be found in any good pediatric text. A basically complete list follows:[5,6]

A. Hyperinsulinemia — ruled out by negative response to intramuscular glucagon
   1) Beta cell hyperplasia
   2) Islet cell adenoma or adenocarcinoma
   3) Nesidioblastosis (hyperplasia of the cells of Islets of Langerhans)
   4) Extra-pancreatic tumors
   5) Beckwith-Wiedemann syndrome (macroglossia, macrocephaly, hepatomegaly, somatic giantism, omphalocele)
   6) Prediabetes
   7) Leucine sensitivity
   8) Maple syrup urine disease
   9) Idiopathic

B. Substrate limited
   1) Ketotic hypoglycemia — represents 65 per cent of all childhood hypoglycemia, characterized by hypoglycemia with ketonuria, glucagon resistance, and small-for-gestational-age infants
   2) Glucagon deficiency
   3) Primary liver disease
   4) Catecholamine insufficiency (Zetterström syndrome)
   5) Endocrine deficiencies (growth hormone, cortisol, etc.)

C. Enzyme defects
   1) Glycogen storage disease — hepatomegaly and growth failure
      a. Glucose - 6 - phosphatase
      b. Amylo - 1,6 - glucosidase
      c. Defects of the phosphorylase cascade system
   2) Gluconeogenetic enzyme defects — Fructose - 1,6 - diphosphatase
   3) Other enzymatic defects
      a. Glycogen synthetase — clinical picture similar to ketotic hypoglycemia
      b. Galactose - 1 phosphatase
      c. Fructose - 1 phosphate aldolase.

D. Due to drugs and toxins
   1) Ethyl alcohol
   2) Salicylates and Tylenol®
   3) Sulfonylureas
   4) Propranolol
   5) Jamaican vomiting sickness

E. Other
   1) Hepatic damage
      a. Reye's syndrome
      b. Leukemia
   2) Malabsorption
   3) Renal glycosuria
   4) Malnutrition
      a. Kwashiorkor
      b. Low phenylalanine diet

These diagnoses can be excluded by history, examination and laboratory studies. Ketotic hypoglycemia, hyperinsulinism and glycogen synthetase deficiency present similar pictures and have to be differentiated. In order to distinguish ketotic hypoglycemia from hyperinsulinism, the diagnosis is confirmed by provoking symptomatic hypoglycemia with fasting or by administration

of a high-fat, ketogenic diet.[4] A glucagon challenge test is then performed.[3] This involves a 24-hour fast with prior baseline blood glucose and insulin levels determined. Subsequently, blood glucose and urine ketones (by Acetest) are determined at four-hour intervals. When the blood glucose level falls to 50 mg/dl (usually 12-24 hours later), glucose and insulin levels are drawn. Usually, in ketotic hypoglycemia, ketonuria develops after less than 6-8 hours of fasting, followed by the appearance of symptomatic hypoglycemia between 12-24 hours. The fast is ended with a one-mg intramuscular injection of glucagon, and blood glucose levels are obtained at five, 10 and 15 minutes after injection. Hypoglycemia that does not respond to glucagon is virtually diagnostic of ketotic hypoglycemia. Insulin levels are within normal limits (normal fasting insulin levels 10-30 IU/ml).

Note that the clinical picture of glycogen synthetase deficiency is similar to that of ketotic hypoglycemia, and also has a minimal response to glucagon.[3] Assay of hepatic glycogen synthetase can be used to differentiate, but among patients labeled ketotic hypoglycemia, persistent hyperglycemia and increase in serum lactate concentration after administration of glucose should reveal those with possible deficiencies of glycogen synthetase. This latter disorder, however, is extremely rare.

Etiology and Pathogenesis

Failure to decrease glucose utilization in response to fasting or a ketogenic diet appears to be the main cause of hypoglycemia in these children. The disorder remits spontaneously with increasing age, usually before eight to nine when glucose production per kilogram body weight is beginning to decrease toward adult values.[2] Using stable isotopically-labeled glucose, it has been demonstrated that the glucose production rate per kilogram of body weight during early childhood is 2-4 times greater than in adults.[2]

The lack of response to glucagon at the time of symptoms suggests depletion of liver glycogen stores. Circulating alanine, the primary gluconeogenic amino acid, is low. There is, however, no abnormality in the gluconeogenic pathway. Certain hypotheses have been put forth for etiology.[2] Briefly they are:

1) a primary defect in the catecholamine response to hypoglycemia.

2) a primary defect in the muscle protein catabolism during starvation leading to unavailability of gluconeogenic substrates, mainly alanine.

3) a primary defect in the cortisol response during hypoglycemia.

Treatment and Prognosis

Intravenous glucose is administered to patients experiencing acute hypoglycemic episodes who are unresponsive to oral glucose; the symptoms remit rapidly. In the interim, a high-carbohydrate, high-protein diet administered with extra feeds at bedtime in conjunction with an early breakfast usually precludes the need for drug therapy. Parents also are instructed to monitor urine for ketones every morning and evening (and every four hours if the child is ill and has had decreased carbohydrate intake) since ketonuria is the harbinger of a hypoglycemic episode. If ketonuria is present, liquids containing high concentrations of glucose should be administered.

Long-term prognosis is good. Risk of mental retardation and intelligence impairment is proportional to the degree of control and frequency of the episodes. An association of delayed speech has been reported in ketotic hypoglycemics but this is a topic for further research. Some reports also have linked this disorder to an increased risk of developing diabetes mellitus, but this also is an avenue for further research.

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Pablo M. Pauig, M. D.	343-8843
Ralph S. Smith, M. D.	925-0349
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A message from . . .

The President

ON BECOMING INVOLVED

"EVERY man owes part of his time and money to the business or industry in which he is engaged. No man has a moral right to withhold his support from an organization that is striving to improve conditions within its sphere."—*Teddy Roosevelt.*

The above quote is especially applicable to the professions, and to our profession of Medicine in particular. Through the years, physicians have enjoyed a certain respect, almost a reverence not accorded to many. There has been reason for this. It has been earned by dedication to the welfare of the patient above all else. The past generations of our peers have handed us a legacy built on their self-sacrifice and personal dedication to the good of the patient. This legacy has sustained our profession.

Regrettably, this may no longer be true. Our profession is under attack from all sides as being cynical, uncaring, greedy and uninvolved. There seems to be a feeling rampant across the country and our state that physicians are interested only in taking from their patients and the community and giving very little in return. I think this is a false perception, but it is a far cry from the image of Medicine as the compassionate, caring profession it historically has been.

We can correct this perception, I feel, by becoming more involved, as individuals and through our organization. It is not enough in our Association to say, "Let Charlie do it" (or Harry, or John, or Carl). We each must take an active interest and become involved in the efforts of our Association. It is not enough, in the political arena, to complain bitterly among ourselves when legislation contrary to the best interests of our patients is enacted. We each must take it upon ourself to investigate the issues, and communicate our concerns to our legislators individually so that they have some knowledge of the impact of their actions. Those actions that benefit our patients will, in the long run, benefit our profession. It may be a cliche to say, "If you are not part of the solution, you are part of the problem," but there does appear to be truth in this.

We also need to become more involved, personally and professionally, with our communities. Nowhere else is John Donne's comment, "No man is an island . . . ," more appropriate. If we physicians are perceived as a "privileged class" and as takers, not givers, each individual instance becomes a reflection on the profession as a whole.

I ask and urge each of you, individually, to become more involved. The whole *is* greater than the sum of all its parts. Any actions of our organization are the results of the accumulation of individual actions by concerned, dedicated physicians; and, if more of us will become more involved and act, the greater influence we can wield for the benefit of our patients.

Harry Shannon MD

HARRY SHANNON, M. D., *President*
West Virginia State Medical Association

The West Virginia Medical Journal

Editorials

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author shall be held entirely responsible. Editorials printed in The Journal do not necessarily reflect the official position of the West Virginia State Medical Association.

INCONSISTENCY

For some very practical reasons, state legislative sessions hardly are models of consistency. In spite of what many might think, 60 days is not a long time in which to deal adequately with budget and other complex matters, particularly in the current era.

As a result of this, political and other very real factors, things happen, and bills are passed, that often go outside the realm of logic. This was the case in 1983 in the general arena of health care costs.

In a near-panic, last-minute move, the Legislature set up a West Virginia Health Care Cost Review Authority and empowered it to—among other things—set hospital rates. This Association regards the act as a poor piece of legislation, for reasons already expressed in *The Journal* and otherwise.

But while it frantically moved to pass this cumbersome piece of so-called cost containment, the Legislature also enacted in its closing hours two other measures that promise to *increase* health care outlays.

One requires accident and sickness insurers to make available coverage for primary health care nursing services, and thus provides the mechanism sought by the West Virginia Nurses Association to help registered nurses—irrespective of levels of training—to move into independent practice.

The other act makes physical therapists direct primary care providers by permitting them to treat persons other than those referred by doctors of medicine and osteopathy, dentists and podiatrists. State law previously has had the referral requirement.

The inconsistency in the legislative action is clear. We have our doubts as to what the effects of the hospital act really will be. But we know of no evidence to indicate that creation of new primary care providers can do anything but increase the cost of health care to the public.

With respect to the nurses measure, we think the public can expect to pay increased insurance premiums for the new coverage, effective next January 1. The insurance industry feels that some companies might not want to make the nurses coverage available, and elect to leave the state. That remains to be seen, of course, but West Virginia now is unique with this type of coverage as a part of statute.

It's also uncertain just how many nurses or groups of nurses might enter independent practice. But with any number at all in such posture, and physical therapists in a generally similar role of independence, the picture is clear. More people will be after the health care dollar.

We must hasten to stress that the Medical Association is not anti-nurse or anti-therapist. It has had a working committee relationship with the nurses association for years, and there's no indication that will change.

Perhaps it's most fitting, at the moment, to recall the words a few years ago of the late Miss Freda Engle, the veteran executive officer of the West Virginia Board of Examiners for Registered Professional Nurses.

The health care system, Miss Engle emphasized, is just that—a *system*. Within that system are appropriate roles for the significant variety of health care providers, according to their expertise and training. But the *system* is of overriding importance.

It has been in that general context that the Medical Association has worked for several years with the nurses' examining board in specific efforts to develop administrative rules, regulations and realistic guidelines for the most effective use of advanced registered nurse practitioners.

It's also significant, perhaps, that in this detailed effort the nurses' board often has found physician comments and suggestions more reasonable than those from many nurses—particularly those who don't have the training enjoyed by those with advanced degrees.

There's the further fact of life that to an ever increasing degree, additional persons and groups are struggling to get a bigger piece of the health care turf.

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It's disturbing and frustrating — and even frightening when one considers the basic element of availability of quality care—to see legislative action which encourages and even directly contributes to this effort—again, irrespective of educational and other provider qualifications.

It can be said in many ways, but it can't be reemphasized too often. "It" is a national issue of the moment—the critical necessity for more and more involvement of physicians in public affairs.

TAKE ACTION

"Complaining about the actions of our elected representatives must be the second most popular indoor sport in our country," observed Darrell Cannon, M. D., the Los Angeles County Medical Association President. "But what they need from us now," Doctor Cannon added, "is input, not complaints."

"Physicians *could* (emphasis ours) have a profound effect on all important issues," the Nebraska Medical Association President, Allan C. Landers, M. D., recently wrote. "To fail to do so is to sacrifice a privilege we and our forebearers have earned."

Doctor Landers stressed that he was not referring "to strictly medical issues, but to any issue that affects all citizens. I would encourage individual input into all levels of government, spanning the spectrum from local school boards right up through the Congress of the United States."

The Nebraska physician then zeroed in on one of the most pertinent points. "*Others, perhaps less informed, do it. Why shouldn't we?*"

The Medical Association of the State of Alabama President, Ronald E. Henderson, M. D., noted the "multitude of dangers and opportunities facing the medical profession at the present time. The threat to the independent practice of medicine is real." He added:

"Because of the magnitude of change about to occur, there is the danger that the system that evolves will represent a threat to the patients that we serve. On the other hand, however, never before in your lifetime or mine has there been such an opportunity to make meaningful contributions."

Nothing these physicians from other states have said is new. Our State Medical Association leadership has emphasized the same general points. But getting real action, in the form of individual and collective physician response, remains the critical problem in West Virginia, and elsewhere.

Contact with legislators, for example, is a year-around necessity. Little really can be accomplished during the short 60 days of an actual legislative session.

Doctor Cannon urged the Los Angeles physicians to take the time and make the effort to meet legislators from their areas. Write or call them about issues that are of concern. And do this regardless of the calendar.

"Our legislators are trying to resolve major problems," Doctor Cannon said. "They will produce better answers for all of us—doctors and patients—if we take the time and make the effort to keep them informed of our opinions and concerns on medical issues."

Again, there is nothing new nor revolutionary in this statement. But it sets forth a critical fact of life. Without much more physician involvement in the world outside the office or hospital, Medicine and quality medical care face an uncertain, and perhaps disastrous, future.

Dwight L. Blackburn, M. D., President of the Kentucky Medical Association, put that same conclusion this way: "The ultimate survival of our profession and its ability to endure and serve succeeding generations is a responsibility each of us must continue to share."

Think about all this. And then do something about it. It's time and effort you cannot afford *not* to find and undertake.

This is June. Next comes July. And then August, with the Medical Association's 116th Annual Meeting. Hopefully, particularly noting the embattled position in which Medicine and patient care now are entrenched, physicians around the state will think more about August 25-27.

HELP WANTED

Those physicians can have, through their local society memberships, 154 delegates in the Association's House of Delegates. This is the policy-making body —potentially the key component in organized Medicine here.

In recent years, component societies have been slow to choose their delegates. Representation at the Greenbrier has been nothing to write home about. All of which means that the issues can't be addressed unless the grass-roots membership does its part.

Selection of delegates has been slow again this year. Local societies need to pick up the pace. The State Association's leadership must have this kind of help and input if it is to be effective.

GENERAL NEWS

Internist, Urologist Speakers For Convention Session

Physicians from Washington, DC, and Akron, Ohio, will participate in a "Symposium on Sexually Transmitted Diseases" during the 116th Annual Meeting of the State Medical Association.

Edmund C. Tramont, M. D., Chief, Infectious Diseases, Department of Bacterial Diseases, Walter Reed Army Institute of Research in Washington, will speak on "Syphilis and Gonococcal

Edmund C. Tramont, M. D.

Jack L. Summers, M. D.

Infections," while Jack L. Summers, M. D., of Akron will discuss "Sexual Mores in the 1980s." Doctor Summers is full-time Chairman of the Department of Urology at Akron City Hospital and Professor and Chairman, Department of Urology, at Northeastern Ohio Universities College of Medicine in Akron.

The symposium will constitute the first general scientific session of the convention Friday morning, August 26.

The Annual Meeting will be held August 25-27 at the Greenbrier in White Sulphur Springs.

Other symposium speakers, as announced previously, will be Lee P. Van Voris, M. D., of Erie, Pennsylvania, until recently Associate Professor of Medicine at Marshall University and now Chief of Infectious Diseases and Hospital Epidemiologist at Hamot Hospital in Erie; and George J. Pazin, M. D., Associate Professor of Medicine at the University of Pittsburgh. Their topics, respectively, will be "Non-Luetic, Non-Gonococcal Venereal Diseases" and "Transmissible Diseases of the Gay Patient."

AMA President to Speak

The Annual Meeting will open with a pre-convention session of the Association's Council and the first session of the House of Delegates on Thursday morning and afternoon, August 25; and end with the second and final House session and reception for new Association officers on Saturday morning and afternoon.

Dr. Frank J. Jirka, Jr., of Barrington, Illinois, as announced previously, will address the first House session on Thursday. He will be installed as President of the American Medical Association this month in Chicago.

Doctor Tramont, a colonel in the U. S. Army Medical Corps, also is Associate Professor of Medicine and Coordinator (Chief), Division of Infectious Diseases, Uniformed Services University of the Health Sciences Medical School, Bethesda, Maryland; and Clinical Associate Professor of Medicine at Georgetown University in Washington.

He is a Fellow of the American College of Physicians and the Infectious Disease Society of America, a Diplomate of the American Board of Internal Medicine, and also a Diplomate, in Infectious Diseases, of that Board.

Doctor Tramont was graduated from Rutgers University, and received his M. D. degree in 1966 from Boston University. He took his post-graduate training at Bellevue (Cornell Division) and Memorial hospitals in New York City, and at Walter Reed.

Doctor Tramont is the author or co-author of some 75 scientific articles and abstracts, plus a number of book reviews.

WVU Graduate

Doctor Summers is a 1966 graduate of West Virginia University School of Medicine, and served his internship and urology residency at Akron City Hospital.

He was in the private practice of urology from 1973 to 1979, at which time he became full-time Chairman of the Department of Urology at Akron City Hospital. Doctor Summers also is Clinical Professor of Urology at WVU. He currently is President of the Cleveland Urological Society and

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President Elect of the Summit County Medical Society, Akron.

Doctor Summers is pursuing a degree in sex education at the Institute for the Advanced Study of Human Sexuality in San Francisco.

Dr. Samuel P. Asper of Philadelphia, also as announced, will deliver the keynote Thomas L. Harris address during opening exercises Friday morning preceding the first general scientific session. Doctor Asper, who is President of the Educational Commission for Foreign Medical Graduates, will speak on "Strengths and Weaknesses of the U. S. Role in International Medicine."

The second and final general scientific session, a "Symposium on Cardiovascular Diseases," will be held Saturday morning. Individual subjects will include new developments in the management of cardiac arrhythmias; an update relative to cardiovascular surgery; and the management of congestive heart failure.

Doctor Adkins To Be Installed

At the final House session on Saturday afternoon, Carl R. Adkins, M. D., of Fayetteville will be installed as the Association's 1983-84 President to succeed Harry Shannon, M. D., of Parkersburg.

In addition to the House and general sessions, the Annual Meeting agenda will include breakfast, luncheon and other programs arranged by specialty societies and sections, many of which also will provide scientific discussions.

The specialty group meetings will be held in large measure on Friday, with a few to be set for Saturday morning, preceding the second general session, and at noon.

The Auxiliary to the State Medical Association, with Mrs. Richard S. Kerr of Morgantown the current President, as usual will hold its meeting in conjunction with that of the Association.

Members of the 1983 Program Committee are David Z. Morgan, M. D., Morgantown, Chairman; Doctor Adkins; Jean P. Cavender, M. D., Charleston; Michael J. Lewis, M. D., St. Marys; Kenneth Scher, M. D., Huntington, and Roland J. Weisser, Jr., M. D., Morgantown.

Information concerning remaining speakers and other convention details will be provided in the July and August issues of *The Journal.*

Greenbrier Reservations Due By July 10

Reservations for the 116th Annual Meeting of the West Virginia State Medical Association should be made with the Greenbrier no later than Sunday, July 10, in order to comply with the hotel's requirement that all reservations must be received no later than 45 days prior to the meeting. Reservation forms provided by the Greenbrier have been distributed to all Association members. Any physicians who need additional forms should write or call the Association's headquarters office in Charleston.

Child Abuse, Drunk Driving Auxiliary Targets

Promoting awareness and prevention of child abuse and drunk driving will be the focus of the American Medical Association Auxiliary's 1983-84 Shape Up for Life campaign.

In 1979, the AMA Auxiliary launched Shape Up for Life, its nationwide program to promote good health. The Shape Up for Life campaign encompasses areas of health such as nutrition, exercise, stress management, and substance abuse.

In 1983-84, Shape Up for Life will focus on Children and Youth, with a special emphasis on prevention of child abuse. Drunk driving also will be spotlighted under the Shape Up for Life umbrella. Promotion of public awareness is the major concern, with new materials available to provide information. Two new brochures, entitled "Child Abuse Prevention" and "Drinking and Traffic Safety," will be available.

Shown above at its April meeting is the Mason County Medical Society, which has become increasingly active in recent months. At the head of the table is Dr. Mel P. Simon, Point Pleasant urologist, President. The meeting was held at Pleasant Valley Hospital in Point Pleasant.

Continuing Education Activities

Here are the continuing medical education activities listed primarily by the West Virginia University School of Medicine for part of 1983, as compiled by Dr. Robert L. Smith, Assistant Dean for Continuing Education, and J. Zeb Wright, Ph. D., Coordinator, Continuing Education, Department of Community Medicine, Charleston Division. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of The Journal.)

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the Morgantown, Charleston and Wheeling campuses. Further information about these may be obtained from: Division of Continuing Education, WVU Medical Center, 3110 MacCorkle Avenue, S. E., Charleston 25304; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 2000 Eoff Street, Wheeling 26003.

June 3-4, Morgantown, Anesthesia Update '83

June 4, Charleston, 10th Annual Wildwater Conference — Medical & Surgical Update

June 11, Morgantown, Interventional Radiology

Regularly Scheduled Continuing Education Outreach Programs from WVU Medical Center/ Charleston Division

Buckhannon, St. Joseph's Hospital, first-floor cafeteria, 3rd Thursday, 7-9 P. M. — June 16, "Sudden Infant Death Syndrome," David Myerberg, M. D.

Cabin Creek, Cabin Creek Medical Center, Dawes, 2nd Wednesday, 8-10 A. M. — June 8, "ENT Update," Ronald L. Wilkinson, M. D.

Gassaway, Braxton Co. Memorial Hospital, 1st Wednesday, 7-9 P. M. — June 1, "Common Blood Disorders," Steven Jubelirer, M. D.

July 6, "The Pharmacology of Hypertension Management," Stephen Grubb, M. D.

Aug. 3, "Diagnosis of Pulmonary Disorders," Dominic Gaziano, M. D.

Madison, 2nd floor, Lick Creek Social Services Bldg., 2nd Tuesday, 7-9 P. M. — June 14, "Recently Recognized Sexually—Transmitted Diseases," Thomas W. Mou, M. D.

July 12, "Approach to the Peripheral Vascular Patient," Ali F. AbuRahma, M. D.

Oak Hill, Oak Hill High School (Oyler Exit, N 19) 4th Tuesday, 7-9 P. M. — June 28, "Protocols for the Treatment of Pit Viper Bites," David Wright, M. D.

Welch, Stevens Clinic Hospital, 3rd Wednesday, 12 Noon-2 P. M. — June 15, "Low Back Injury" (a special program in cooperation with Workers' Compensation Fund of W. Va., speaker to be announced)

Whitesville, Raleigh-Boone Medical Center, 4th Wednesday, 11 A. M.-1 P. M. — June-August (summer break)

Williamson, Appalachian Power Auditorium, 1st Thursday, 6:30-8:30 P. M. — June 2, "Proper Utilization of the Clinical Laboratory," Bobby Lee Caldwell, M. D.

Management/Lab Workshops June 16-17, Beckley

Health delivery management, intestinal parasitology, and abnormal white/red blood cell morphology will be the three workshop subjects for the Summer Management/Laboratory Conference June 16-17 in Beckley at the Ramada Inn.

Sponsors are Hygeia Facilities in Oceana and West Virginia University Medical Center, Charleston Division.

The two-day parasitology wet workshop will be conducted by John E. Hall, Ph.D., Professor of Microbiology, WVU Medical Center. The hematology workshop, a seven-hour option on the 17th, will be led by William Koss, M.D., Director of Hematology and Coagulation Laboratories; Marta J. Henderson, M.S., Department of Medical Technology; and Deborah A. Jones MT(ASCP), Hematology Laboratory, all from the WVU Medical Center.

The one-day management workshop on June 16 will be conducted by Albert E. Giles and Jon V. Straumfjord, M. D., Ph.D., Kirkwood, New Jersey. Current Medicare-Medicaid legislation

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will be among laboratory management topics covered.

A total of .7 Continuing Education Unit (CEU) Credits may be earned each of the two days. All health professionals are invited, particularly administrative and technical laboratory personnel. Registration fee is $20 per day.

Further information and registration forms may be obtained from Junemarie Bowling, MT(ASCP), Conference Chairperson, Hygeia Facilities, Box 400, Oceana 24870. Telephone (304) 682-6246 (6247).

Membership Amendments Set For House Vote

Up for final action at the first session of the State Medical Association's House of Delegates August 25 at the Greenbrier will be constitution and bylaws amendments to make residents in their first year of approved training eligible for Association membership.

Under current state law, those first-year residents are not eligible for licensure (they work under an educational training permit issued by the West Virginia Board of Medicine), and thus also are not eligible for Association membership pending licensure.

Here is the language of the proposed constitution and bylaws changes:

AMENDMENTS TO THE CONSTITUTION

(Approved by the Committee on Constitution and By-Laws, Executive Committee and the Council, August 25-26, introduced into House of Delegates August 26, 1982, and subject to action by the House August 25, 1983.)

Sec. 1. This Association shall consist of active, retired, honorary, *resident* and student members.

Sec. 2. Members. Membership in the Association shall be limited to doctors of medicine licensed to practice in West Virginia who are members of a component medical society of the West Virginia State Medical Association; *residents who are licensed to practice medicine in West Virginia, or who are serving in internship/residency training programs approved by the West Virginia Board of Medicine prior to meeting requirements for licensure;* and students enrolled in accredited schools of medicine in West Virginia granting Doctor of Medicine degrees.

Sec. 6. Resident members shall be those persons who are licensed to practice medicine in West Virginia, or who are serving in internship/residency training programs approved by the West Virginia Board of Medicine prior to meeting requirements for licensure, and who are qualified for membership under the By-Laws of this Association.

ARTICLE XIV.—AMENDMENTS

Sec. 1. The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in THE WEST VIRGINIA MEDICAL JOURNAL, or sent officially to each component society, and *resident and* student members whose names are listed on the official roster of the Association at

Review A Book

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication.

Basic and Clinical Pharmacology, by Bertram G. Katzung, M. D., Ph.D. 815 pages. Price $23.50. Lange Medical Publications, Los Altos, California 94022. 1982.

Current Medical Diagnosis and Treatment, 1983, edited by Marcus A. Krupp, M. D.; and Milton J. Chatton, M. D. 1130 pages. Price $24. Lange Medical Publications, Los Altos, California 94022. 1983.

General Ophthalmology, 10th Edition, by Daniel Vaughan, M. D.; and Taylor Asbury, M. D. 407 pages. Price $17. Lange Medical Publications, Los Altos, California 94022. 1983.

Neuroanatomy: An Atlas of Structures, Sections, and Systems, by Duane E. Haines, Ph.D., Professor of Anatomy, West Virginia University School of Medicine, Morgantown. 212 pages. Price $19.50. Urban & Schwarzenberg Medical Publishers, 7 East Redwood Street, Baltimore, Maryland 21202. 1983.

least two months before the meeting at which final action is to be taken.

(Words in italics indicate new portion to be added or a change in old verbage. The purpose of the amendments is to provide eligibility for State Association membership for interns/residents in their first year of approved training. before they can be licensed under state law.)

AMENDMENT TO THE BY-LAWS

(Approved by the Committee on Constitution and By-Laws, Executive Committee and the Council, August 25-26, also introduced in House August 26, 1982, and now awaiting action by the House August 25, 1983.)

Sec. 1. The name of a physician on the properly certified roster of members of a component society shall be prima facie evidence of membership in this Association, provided he has paid local and state dues and any current assessment, and provided further that he is licensed to practice medicine in West Virginia. The membership also shall include, upon payment of state dues and any current assessment; *a resident licensed to practice medicine in West Virginia, or who is serving in an internship/residency training program approved by the West Virginia Board of Medicine prior to meeting requirements for licensure; and* a student enrolled and working toward a Doctor of Medicine degree, in any accredited school of medicine in West Virginia; provided, further, that the academic status of each medical student applicant for membership shall be certified by the dean of his medical school.

Sec. 4. Each member in attendance at an annual session shall register and indicate the component society, or *Resident or* Medical Student Section, of which he is a member. When his right to membership has been verified by reference to the roster of his society, *Resident or* Medical Student Section, he shall receive a badge which shall be evidence of his right to all privileges of membership at that session. No member shall take part in any of the proceedings of an annual session until he has complied with the provisions of this Section.

(Note: New language is set in italics. The amendment would make an intern/resident in his first year of approved training, and prior to licensure under state law, eligible for State Medical Association membership and thus provide for implementation of the preceding constitutional amendment.)

ACP Fellow

Dr. Thomas W. Mou of Charleston was named a Fellow of the American College of Physicians at the organization's recent annual meeting in San Francisco. Doctor Mou is Dean of the Charleston Division, West Virginia Medical Center, and former Acting Vice Chancellor for the West Virginia Board of Regents (1979-82).

Dr. Earl L. Fisher of Gassaway, whose career spans nearly 50 years, received the "Mister Doc" Award, the highest honor bestowed by the West Virginia Chapter, American Academy of Family Physicians, during the Academy's annual scientific assembly held recently in Morgantown. In the left photo, Doctor Fisher and some of his family are shown following presentation of the award. In the right photo are new AAFP officers for 1983-84 who were installed during the meeting. They are, from left, Drs. William H. Harriman, Jr., Terra Alta, President Elect; Joseph B. Reed, Buckhannon, Vice President; Michael J. Lewis, St. Marys, Secretary; Robert D. Hess, Clarksburg, Chairman of the Board; A. Paul Brooks, Jr., Parkersburg, President; John L. Fullmer, Morgantown, Alternate Delegate, AAFP; and L. Dale Simmons, Clarksburg, Delegate, AAFP. Not shown is Dr. John V. Merrifield, Charleston, Treasurer.

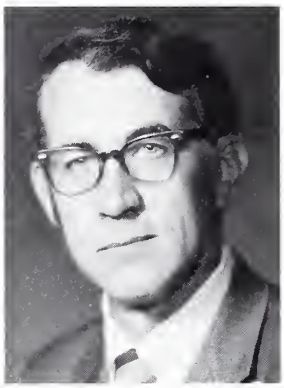
HEALTH SCIENCES LIBRARY

AMA House of Delegates Meets June 19-23

The annual meeting of the American Medical Association's House of Delegates will be held June 19-23 in Chicago at the Marriott Hotel.

The West Virginia State Medical Association's two Delegates to the AMA House of Delegates are Drs. Frank J. Holroyd of Princeton and

Frank J. Holroyd, M. D.



Harry S. Weeks, Jr., M. D.

Harry S. Weeks, Jr., of Wheeling, with Drs. Jack Leckie of Huntington and Joseph A. Smith of Dunbar as Alternate Delegates.

The House of Delegates is composed of representatives from state medical associations, national medical specialty societies, resident physicians, medical students, medical schools and other medical groups.

Dr. William Y. Rial of Swarthmore, Pennsylvania, is President of the AMA. President Elect is Frank J. Jirka, M. D., of Barrington Hills, Illinois, who will assume the presidency during the meeting.

New Feature

The program for the State Association's Annual Meeting August 25-27 at The Greenbrier will have a new feature. Being arranged for Saturday night is a dinner open to the membership to honor the new Association and Auxiliary officers, and recognize those who have served in 1982-83.

The black-tie affair's guests will include visiting Presidents from other states and their spouses, and from the American Medical Association. Ticket and other information will be forthcoming in July and August issues of *The Journal*. The Auxiliary's current plans are to delete from its activities a Friday night social affair it has held for some time, and to participate in the August 27 dinner.

Medical Meetings

June 5-9—Am. Society of Colon & Rectal Surgeons, Boston.

June 7-10—Society of Nuclear Medicine, St. Louis.

June 16-17—Summer Management/Laboratory Conference (Hygeia Facilities and WVU Medical Center, Charleston Div.), Beckley.

June 17-18—Society for Vascular Surgery, San Francisco.

June 19-23—Annual Meeting of AMA House, Chicago.

June 22-25—Am. College of Surgeons, Eastsound, WA.

June 23-26—Am. Medical Women's Assoc., Minneapolis.

Aug. 25-27—116th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

Sept. 29-Oct. 1—Am. Assoc. for the Surgery of Trauma.

Sept. 29-Oct. 2—Am. Society of Internal Medicine, San Francisco.

Oct. 2-5—Am. Neurological Assoc., New Orleans.

Oct. 5-8—Am. Thyroid Assoc., New Orleans.

Oct. 16-21—Am. College of Surgeons, Atlanta.

Oct. 22-27—Am. Academy of Pediatrics, San Francisco.

Oct. 23-27—Am. College of Chest Physicians, Chicago.

Oct. 23-29—Am. College of Gastroenterology, Los Angeles.

Oct. 24-27—Am. College of Emergency Physicians, Atlanta.

Nov. 6-9—Scientific Assembly, Southern Medical Assoc., Baltimore.

Nov. 30-Dec. 1—Am. College of Chemosurgery, Chicago.

1984

Jan. 27-29—17th Mid-Winter Clinical Conference, Charleston.

March 17—Annual Meeting, W. Va. Affiliate, American Diabetes Assoc., Wheeling.

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HEALTH SCIENCES LIBRARY

WVU Medical Center
–News–

Compiled from material furnished by the Medical Center News Service, Morgantown, W. Va.

Toxic Shock Still Problem As Publicity Dwindles

Toxic shock syndrome continues to be a medical problem despite removal from the market of high absorbency tampons believed to predispose menstruating women to infection.

In fact, 10 per cent of all cases diagnosed as toxic shock syndrome have no direct relation to menstruation, according to Larry G. Reimer, M. D., Director of the Clinical Microbiology Laboratory.

Doctor Reimer, who also is Assistant Professor of Medicine and Pathology, said public awareness probably had resulted in patients seeking medical help earlier and a lowering of the mortality rate.

"But on the other hand, a lot of publicity about toxic shock syndrome has now died down," he said. "Some physicians may have reached a point where they think it's not a problem anymore.

Not Always Recognized

"That's really not the case. Of the three patients treated at the Medical Center since the first of the year, one had been seen by two or three physicians before diagnosis. So it's not something that everybody immediately recognizes even now.

"Staphylococcus aureus is a commonly occurring bacteria," he explained. "Anywhere from 20 to 40 per cent of all women will have it in vaginal cultures. Just having the organism there doesn't say anything about toxic shock."

But a large growth of the microorganism combined with typical symptoms would confirm the diagnosis after other diseases such as scarlet fever, scalded skin syndrome, Rocky Mountain spotted fever or measles had been ruled out.

Symptoms are a fever of more than 101 F., a systolic blood pressure reading of less than 90, a rash and multi-system involvement manifested by mental confusion, nausea and vomiting, diarrhea, kidney or liver impairment, anemia, or decreased blood clotting elements.

"If we get a vaginal culture that grows a large amount of staph aureus, we always call the physician because the laboratory slips don't always tell us what diagnosis is being considered," Doctor Reimer said.

"If we know the clinical diagnosis of toxic shock syndrome is suspected, we specifically look for staph aureus."

The illness is caused by a toxin secreted by the bacteria, Doctor Reimer said. Those cases not associated with menstruation occur when the microorganism enters the body through surgical wounds, skin lesions or following childbirth. In the case of surgical wounds, there is usually no local inflammation, pain or tenderness.

Female Donors' Blood Depletion Faster, Says Researcher

A WVU Medical Center researcher against equal rights for women?

No, but S. N. Jagannathan, Ph.D., is against a U. S. Food and Drug Administration rule which does not discriminate between men and women when it comes to frequency of repeat blood donations.

Doctor Jagannathan recently told the Federation of American Societies for Experimental Biology his study indicates that maximum giving can deplete the body's iron storage status and that women are much more at risk than men.

Doctor Jagannathan, Associate Professor of Pathology and Biochemistry, and graduate student Gary Stoner studied 328 blood donors.

Current FDA rules, approved by the American Association of Blood Banks, let male and female donors give a unit of blood every eight weeks. Doctor Jagannathan said his investigation shows that at the present eight-week limit, donors' iron stores do not get replenished from the typical American diet alone.

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Third-Party News, Views and Program Concerns

Welfare Clarifies Medicaid Office Visit Coverage

The West Virginia Department of Welfare is providing clarification for the state's physicians relative to coverage of office visits under the Medicaid Program. Current experience is reflecting some apparent misunderstanding of such coverage.

The program coverage provides reimbursement for one medical service per day; i.e., Medicaid covers one "visit procedure" daily. Further amplification of this provision will be provided in notices to individual doctors.

Because of processing program errors, payment has been made in the past for a combination of daily visits. Now, as the erroneous payments might be identified, physicians will be notified and steps taken to adjust the claims.

In the future, the Department explained, such combination claims will bring a denial for payment. A remittance statement will read, "This claim conflicts with a previously submitted claim." The conflicting claim (the paid claim) also will be listed on the remittance voucher.

The Department said some examples of conflicting service situations have been identified as an office visit and a home visit in one day; office visit and nursing home visit; office visit and emergency room visit; emergency room visit and hospital visit; office visit and hospital visit; office visit and consultation; nursing home visit and office visit, and surgery and another type of visit.

Reagan Applauds Free Care For U.S. Unemployed

President Reagan has applauded voluntary efforts by state, county and national specialty societies to provide free and low-cost medical care to the nation's unemployed. In a recent White House meeting commemorating National Volunteer Week, medical society representatives told the President about their programs for "newly needy" patients who are ineligible for Medicare and Medicaid, have no health insurance, or are otherwise unable to pay. The programs included free clinics, health screening, and no-cost or low-cost medical and surgical services.

AMA President William Y. Rial, M. D., presented Reagan with a report on 23 health programs for the unemployed. Reagan told Doctor Rial, "You know how strongly I believe in the power of private sector initiatives—almost as much as some of those old home remedies that my mother used to use. One thing is for sure, I know that local efforts such as those I've just heard about can help tremendously in curing the ills of our country."

New Ways To Protect Newborns With Handicap Explored

American Medical Association representatives met recently with U. S. Department of Health and Human Services officials to discuss alternative approaches for implementing the White House mandate to protect severely handicapped newborns. Earlier, U. S. District Court Judge Gerhard A. Gesell had struck down new federal regulations that required hospitals to post notices in delivery rooms and nurseries publicizing a 24-hour, toll-free hot line to be used in cases of suspected neglect.

Following Judge Gesell's ruling, AMA staff and representatives from the American Academy of Pediatrics, American College of Obstetrics and Gynecology, Federation of American Hospitals, American Hospital Association, and the National Association of Children's Hospitals met for two hours with John Svahn, Undersecretary of Health and Human Services, and C. Everett Koop, M. D., Surgeon General of the U. S. Public Health Service. The medical organizations were unanimous in their opposition to the rulemaking, and advised HHS to enlist the cooperation of the professional community.

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Obituaries

WILLIAM E. ANDERSON, M. D.

Dr. William E. Anderson of Cumberland, Maryland, formerly of Morgantown, died on April 4 in Cumberland. A gastroenterologist, he was 55.

Doctor Anderson was a member of the faculty of the West Virginia University School of Medicine from 1960 to 1980, when he resigned to begin group practice in Cumberland. He was head of the Gastroenterology Section at WVU.

A native of Mankato, Minnesota, Doctor Anderson was graduated from Gustavus Adolphus College in St. Peter, Minnesota, and received his M. D. degree in 1954 from the University of Minnesota.

He was a former member of the Monongalia County Medical Society and the West Virginia State Medical Association.

Survivors include the widow; a son, Evan Anderson, at home; the stepmother, Mrs. Evan Anderson of San Francisco, and a brother, Dr. Richard Anderson of Eugene, Oregon.

* * *

SPENCER L. BIVENS, M. D.

Dr. Spencer L. Bivens, retired Charleston surgeon, died on May 3 in a nursing home there. He was 82.

A veteran of World War II, Doctor Bivens was President of the Kanawha Medical Society in 1947.

He was born in Meadow Bluff (Greenbrier County).

Doctor Bivens received his M. D. degree in 1928 from Emory University, and completed postgraduate work at Maryland General Hospital in Baltimore and Charleston General Hospital.

He was an honorary member of the Kanawha Medical Society, West Virginia State Medical Association and American Medical Association.

Survivors include a son, Dr. Spencer L. Bivens, Jr., of Charleston; a daughter, Mrs. Sara Dawkins of Marietta, Georgia; and a brother, Carl Bivens of Alderson.

* * *

RICHARD W. WINGFIELD, M. D.

Word has been received by *The Journal* of the death of Dr. Richard W. Wingfield on January 7 in Keller, Virginia. He was 57.

A native of Elkins, Doctor Wingfield was graduated from West Virginia University, and received his M. D. degree in 1952 from the Medical College of Virginia.

Survivors include the widow and three sons, all of Keller.

* * *

JAMES E. WOTRING, M. D.

Dr. James E. Wotring of Fairview (Marion County), retired family physician, died on March 5 in a Morgantown hospital. He was 61.

Doctor Wotring was a former member and President (1963-64) of the Marion County Medical Society, and a former member of the West Virginia State Medical Association.

Survivors include the widow; two daughters, Mrs. Ronnie Tucker of Morgantown and Mrs. Paul Carns of Latrobe, Pennsylvania; four brothers, Ernest H. Wotring of Marshall, Texas; Daniel J. Wotring, Jr., of Clinton, Maryland; Donald R. Wotring of Artesina, New Mexico, and William R. Wotring of Morgantown; and three sisters, Mary Shafer of Marlinton, Eleanor Wotring of Morgantown and Mrs. Edward Warsinsky of Morgantown.

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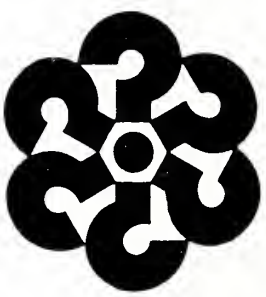

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County Societies

McDOWELL

The McDowell County Medical Society met on April 13 in Welch at Stevens Clinic Hospital.

Dr. John Goldman. Assistant Professor of Medicine, Rheumatology and Immunology, at Emory University in Atlanta, was guest speaker. His subject was the management of rheumatic diseases. He stressed the importance of a physical therapy program for the rheumatic patient.

The Society voted to make a donation equal to the 1982 amount to Camp Kno Koma.—John S. Cook, M. D., Secretary.

* * *

TYGART'S VALLEY

Dr. Charles Howell, a psychologist from the Appalachian Mental Health Center in Buckhannon, presented a workshop on "Instant Aging" for the meeting of the Tygart's Valley Medical Society on April 21.

Held at Broaddus Hospital in Philippi, the purpose of the workshop was to enable volunteer participants from the audience to experience and understand the age-related medical complaints of the elderly, particularly the low-grade chronic losses in their daily routine.

The volunteer subjects were "instantly aged" by plugging their ears with cotton balls, wearing rubber gloves and taping the joints of the hands, wearing goggles smeared with mineral oil, etc. —Halberto G. Cruz, M. D., Secretary.

* * *

FAYETTE

The Fayette County Medical Society held a combined meeting with its Auxiliary on April 6 at the White Oak Country Club in Oak Hill.

The guest speaker was the Honorable Judge Robert Abbot, who discussed criminal law, and compared the English and American judicial systems.—Serafino S. Maducdoc, Jr., M. D., Secretary-Treasurer.

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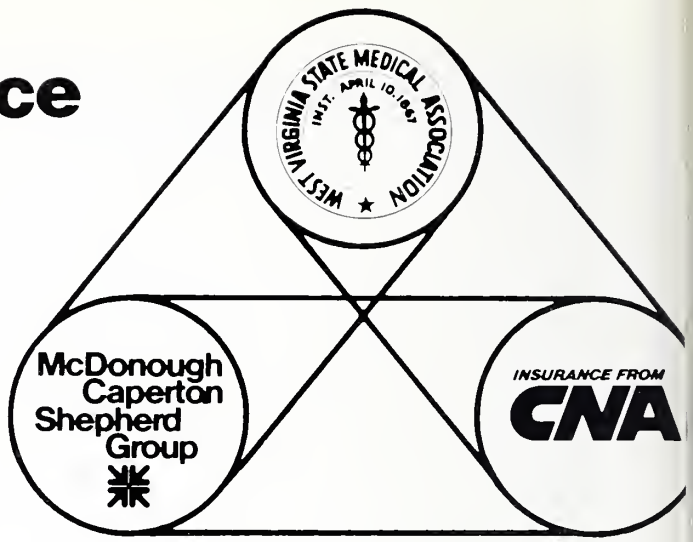

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The West Virginia Medical Journal

Vol. 79, No. 7 July, 1983

Value And Limitations Of The Noninvasive Laboratory: Experience With Over 5,000 Patients

ALI F. ABURAHMA, M. D.
Director, Noninvasive Vascular Laboratory, Charleston Area Medical Center, Charleston, West Virginia; and Clinical Associate Professor in Surgery, West Virginia University Medical Center, Charleston Division.

LINDA OSBORNE, L.P.N.
Vascular Technologist, Charleston

Today, the physician is assisted in the management of vascular diseases by the various noninvasive diagnostic modalities offered by the vascular laboratory. The idea of having a vascular laboratory has become popular in most of the major medical centers in the last decade. In 1978, a vascular laboratory was established at the Charleston Area Medical Center to provide diagnostic testing for carotid artery disease or cerebral ischemia, arterial occlusive disease of lower and upper extremities, and deep vein thrombosis of the extremities.

The purpose of this article is to define the value of the noninvasive vascular laboratory in the diagnosis of vascular disorders, to describe some of its occasional limitations, and to present the results of over 5,000 patients tested in the laboratory from August, 1978, through March, 1982. Emphasis is placed on tests available in our laboratory.

Carotid Artery Disease

Various noninvasive diagnostic modalities have been described for the diagnosis of carotid artery stenosis; e.g., oculoplethysmography (OPG); Doppler ultrasound (continuous wave); ophthalmodynamometry; thermography; pulsed Doppler arteriogram; B-image scanning; real-time, B-image scanning; spectrum sound analysis; new duplex scanning; color-coded Doppler ultrasound (echo-flow), and carotid phonoangiography (CPA). Table 1 shows what is available in the laboratory.

There are essentially two types of oculoplethysmography (OPG) devices:

Ocular Pulse Timing OPG (Kartchner-OPG and Zira OPG). This test is based on comparison of the time of arrival of the arterial pulse at each eye. When no disease is present, both pulses arrive simultaneously. Pulse delay in one eye usually signifies a narrowing or blockage of the internal carotid artery on the affected side; e.g., left internal carotid artery stenosis produces a delayed pulse to the left eye and thus a visible delay in the left ocular wave tracing (Figure 1a & b).

Ophthalmic Artery Pressure OPG (Pneumooculoplethysmography) (OPG-Gee). This test is based on comparison of the two ophthalmic systolic pressures with each other and with the supine brachial systolic pressure. Using certain guidelines outlined by Doctor Gee in his

TABLE 1

What Is Available in the CAMC Vascular Laboratory For the Noninvasive Diagnosis of Carotid Artery Stenosis

1. Oculoplethysmography (OPG/Zira)
2. Oculoplethysmography (OPG/Gee)*
3. Carotid Phonoangiography (CPA)
4. Carotid arterial Doppler ultrasound
5. Real-time B-image carotid scanner*

*The tests we recommend currently

original work on this machine,[11] the diagnosis of significant carotid stenosis can be made (Figure 1c).

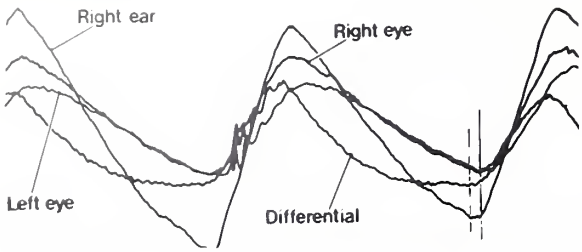

Figure 1a. An oculoplethysmography (OPG) of a patient with left carotid artery stenosis.

Figure 1b. Carotid arteriogram showing the left carotid stenosis.

Figure 1c. OPG-Gee technique.

Clinical Experience

Using pulse timing OPG, 161 patients (309 carotid arteries) from 2,300 OPGs done at Charleston Division, West Virginia University Medical Center, from September, 1978, to September, 1981, were studied in comparison with the carotid arteriograms. The age range was 36 to 78 years.

All the angiograms were reviewed by a radiologist and one or two vascular surgeons. For practical purposes, the radiological findings were classified as follows: a normal carotid artery, mild disease, less than 40-per cent stenosis; significant stenosis, > 40-per cent up to 99-per cent stenosis; and total occlusion. The results are shown in Table 2.

We concluded that OPG is valuable in the diagnosis of normal carotid arteries, unilateral significant carotid stenosis, significant carotid stenosis on one side and mild stenosis on the other side, and unilateral complete carotid occlusion. We also concluded that OPG has limited value (around 56 per cent) in the diagnosis of bilateral significant carotid stenosis.

Of 550 patients using OPG/Gee, 100 had arteriograms. Results are shown in Table 3. We concluded that OPG/Gee is more valuable in the diagnosis of both unilateral and bilateral significant carotid stenosis (90.3 per cent and 90.4 per cent).

TABLE 2
Correlation of Pulse Timing OPG With Arteriogram

			Bilateral Carotid Disease			
	Normal Carotid Arteries	*Unilateral Significant Carotid Stenosis*	*Mild on one side & significant stenosis on the other side*	*Bilateral significant stenosis*	*Total*	*Total Occluded Arteries*
OPG/Zira	101	61	32	15	47	13
Arteriogram	92	53	40	27	67	12
Accuracy	91%	87%	80%	56%	70%	92%

TABLE 3
Correlation of OPG/Gee With Arteriogram

	Normal	*Unilateral significant stenosis*	*Bilateral significant stenosis*	*Total*
Arteriogram	48	31	21	100
OPG/Gee	45	28	19	92
Accuracy	94%	90.3%	90.4%	92%

Discussion

The value of the OPG has been well established in the diagnosis of significant carotid artery stenosis.[2,5,11,12,13,14] It is to be noted that neither the OPG nor any indirect method has been of value in detecting any hemodynamically non-significant carotid stenosis of less than 40 per cent. Those nonsignificant stenoses can be associated with ulcers which have the ability to cause embolization (transient ischemic attack).

Many advantages of OPG give evidence of its practicality. OPG is administered quickly and inexpensively. While being well-tolerated by the patient, it allows for identification of significant carotid stenotic lesions. Certain limitations, however, must be noted. The accuracy is poor in nonhemodynamically significant stenosis of less than 40- or 50-per cent stenosis. It cannot identify an ulcerative plaque if not associated with significant stenosis. Sometimes, differentiation between severe stenosis and complete occlusion cannot be determined. Some OPGs are limited in bilateral significant stenosis.

B-Mode Image Carotid Scanning (and Real-Time, B-Image Scanning)

Now available are instruments producing gray-scale images of high resolution and accurately identifying atherosclerotic disease at or near the carotid arterial bifurcation. Real-time presentation of these images using a hand-held transducer provides an immediate visualization of the lesion and reduces problems associated with locating the artery and positioning the patient. Videotapes of the images can be stored for reevaluation or comparison with previous or subsequent scan data (Figure 2a through e). These direct methods, particularly the real-time, B-image scanner, visualize the carotid artery directly and detect even mild stenotic lesions as compared with the OPG.

In our laboratory, we presently combine both OPG/Gee and the real-time carotid image scanner.

The recommended protocol for the diagnosis of carotid artery disease is shown in Figure 3.

Arterial Occlusive Disease of Lower Extremities

Testing for arterial occlusive disease of the lower extremities employs various noninvasive modalities which have been described in the diagnosis of peripheral vascular occlusive diseases (PVOD); e.g., pulse volume detectors; thermography; Doppler ultrasound (continuous wave); plethysmography; pulsed Doppler arteriography;

Figure 2a. The real-time-B-mode-carotid image scanner.

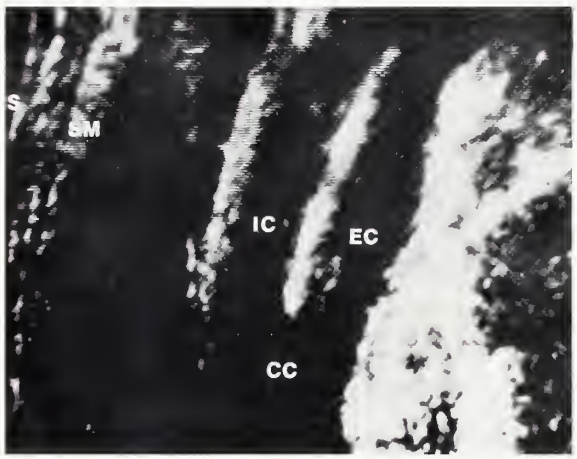

Figure 2b. Real-time, B-image-carotid scan showing normal common carotid (CC), internal carotid (IC) and external carotid (EC).

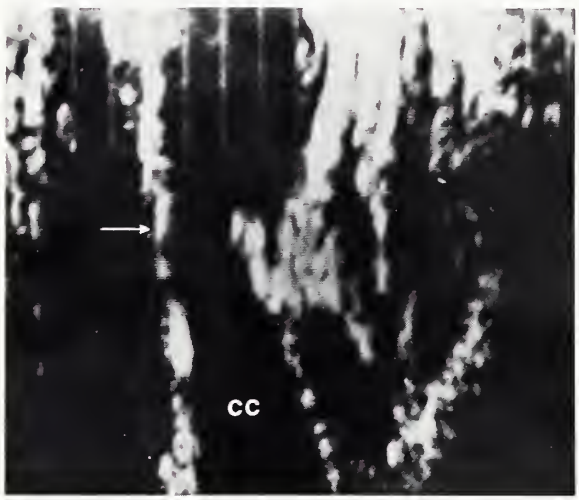

Figure 2c. Real-time, B-image scan showing mild stenosis at the carotid bifurcation.

B-image scanning; real-time, B-image scanning; new duplex scanner, and spectrum sound analysis.

The most common method being used in this country is the Doppler ultrasound instrumentation (continuous wave). This method is employed in our vascular laboratory. The value of the Doppler ultrasound in the diagnosis of peripheral vascular occlusive disease has been well documented.[1,3,4,6,16,17]

Clinical Material, Methods and Results

Between August, 1978, and March, 1982, 1,030 patients had arterial leg Doppler studies

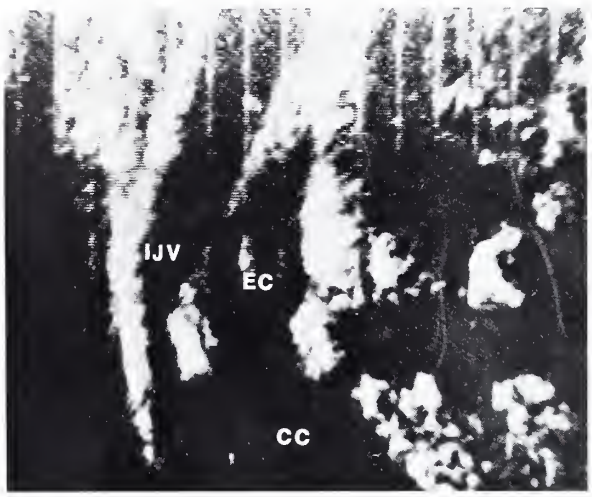

Figure 2d. Real-time, B-image scan showing complete occlusion of the internal carotid artery (CC: common carotid, EC: external carotid, and IJV: internal jugular vein).

Figure 2e. The same patient (2d) with complete occlusion of the internal carotid artery (arteriogram).

(ALD) with or without exercise. Table 4 shows the indications for these tests. We selected the first 150 patients (300 limbs) who had both ALD and arteriograms for this study.

Each limb was studied in four arterial segments: 300 iliofemoral, 300 femoral, 282 popliteal, and 275 trifurcation segments. Eighteen popliteal and 25 trifurcation segments were excluded because of the lack of angiographic visualization (not enough dye).

Every arterial Doppler examination consisted of an evaluation of segmental leg pressures, analysis of the leg pressures in correlation with the arm pressures (ankle/arm index), arterial wave tracing, and, if indicated, an exercise test. The arm systolic pressure and the segmental leg pressures were recorded from blood pressure

TABLE 4

Indications for Arterial Doppler Examination

1. Calf pain while walking.
2. Leg pain at rest.
3. Skin changes suggestive of arterial insufficiency.
4. Nonhealing ulcers.
5. Previous vascular reconstructive procedures.

TABLE 5

Segmental Pressure and Ankle/Arm Index in a Patient With Occlusion of the Left Superficial Femoral Artery

Resting	*Right (Normal)*	*Left (Abnormal)*
Arm	150	160
High thigh	200	206
Above knee	184	150
Below knee	168	144
Ankle (posterior tibial)	150	128
Ankle (dorsalis pedis)	150	128
Ankle/arm index	(150/150)1.0	(128/160).80

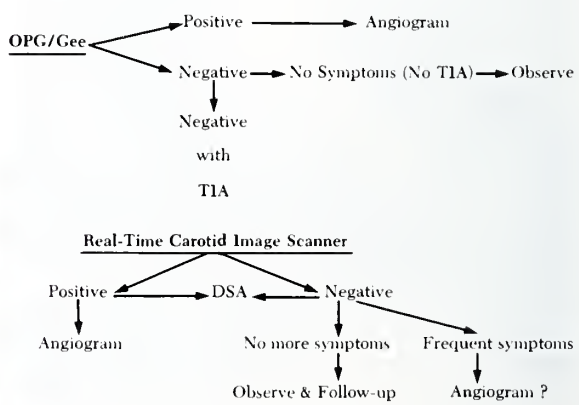

Figure 3. Recommended protocol for the diagnosis of carotid artery disease.

cuffs placed at the high area of the thigh, above the knee, below the knee, and at the ankle (Figure 4). Resting segmental systolic pressures were taken at each level, and the highest reading of the posterior tibial and dorsalis pedis systolic pressures was used as the ankle pressure. The ankle/arm index was then calculated. The presence of greater than 30 mm. Hg gradient between any adjacent level in the leg indicates significant occlusive disease (Table 5).

TABLE 6

Segmental Pressure Reading and Ankle/Arm Index After Exercise in a Patient With Severe Peripheral Vascular Occlusive Disease of the Left Leg

After Exercise	*Right Ankle (Normal)*	*Left Ankle (Abnormal)*	*Arm*
1 minute	186	50	180
2 minutes	186	58	180
4 minutes	180	60	176
6 minutes	180	70	170
10 minutes	166	78	160
15 minutes	170	90	162
20 minutes	170	130	162
Ankle/arm index	(186/180)1.03	(50/180)0.27	

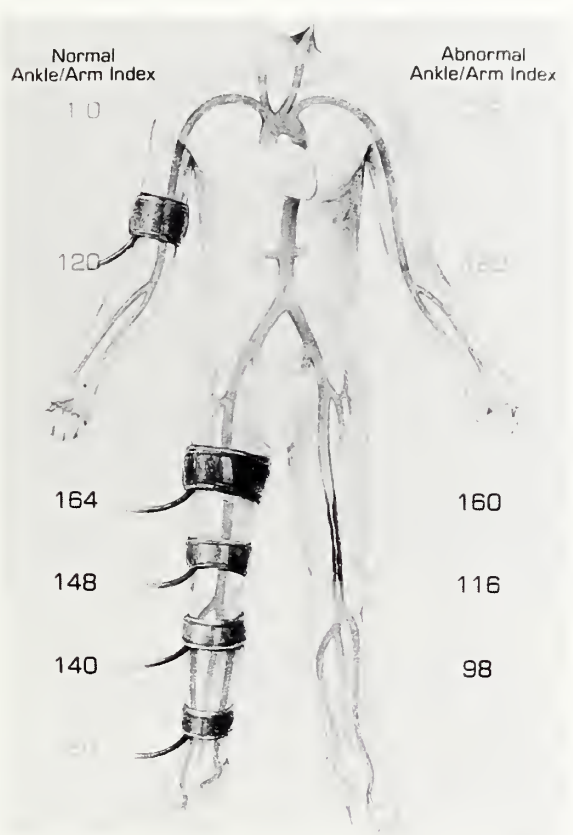

Figure 4. Arterial leg Doppler study showing the segmental Doppler pressures. Note that this study shows significant stenosis of the left superficial femoral artery.

Minimal and/or moderate disease is sometimes not manifested without exercise, so exercise tests are done if indicated. The ankle/arm pressures are then taken after exercise and recorded at timed intervals until they return to pre-exercise levels (Table 6). The blood flow is indirectly assessed by determining the velocity in the form of analogue wave tracings. Normally, an analogue wave tracing has a sharp systolic and one or more diastolic components. Abnormal tracings caused by atherosclerotic disease may show a lack of diastolic components and/or diminished systolic components (Figure 5).

The results are shown in Table 7. We concluded that this method is very helpful in the diagnosis of arterial occlusive disease of the lower extremities with 94-per cent accuracy.

Deep Vein Thrombosis of Lower Extremities

The fallibility of the clinical diagnosis of deep venous thrombosis (DVT) has led to a variety

TABLE 7

Correlation of Arterial Doppler Studies and Arteriograms (Total Segments Studied)

Segments	*Total segments studied by Arterial Doppler*	*Findings confirmed by Arteriograms*	*% Accuracy*
Iliofemoral	300	282	93%
Femoral	300	280	95%
Popliteal	282	262	94%
Trifurcation	275	262	94%
Total	1,157	1,086	94%

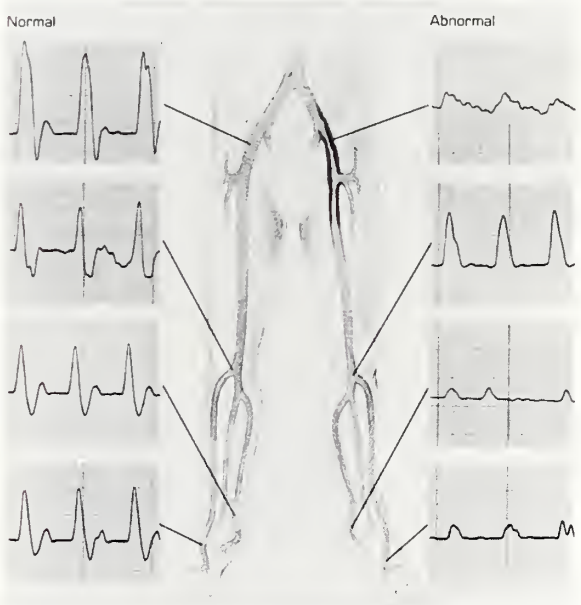

Figure 5. Analogue arterial wave tracing, normal right side and abnormal left side.

of noninvasive diagnostic modalities like: Doppler ultrasound, impedance, air, mercury and strain gauge plethysmograph, I-25 fibrinogen, and radionuclide phlebography.

The strain gauge plethysmography (SPG), the impedance plethysmograph (IPG), and the Doppler venous ultrasound are probably the most common tests used in this country for the diagnosis of deep vein thrombosis (DVT). In our laboratory, we have been using the strain gauge plethysmography and sometimes I-25 fibrinogen leg scanning.

Figure 6. The technique of the strain gauge plethysmography (SPG) for the diagnosis of deep vein thrombosis (DVT).

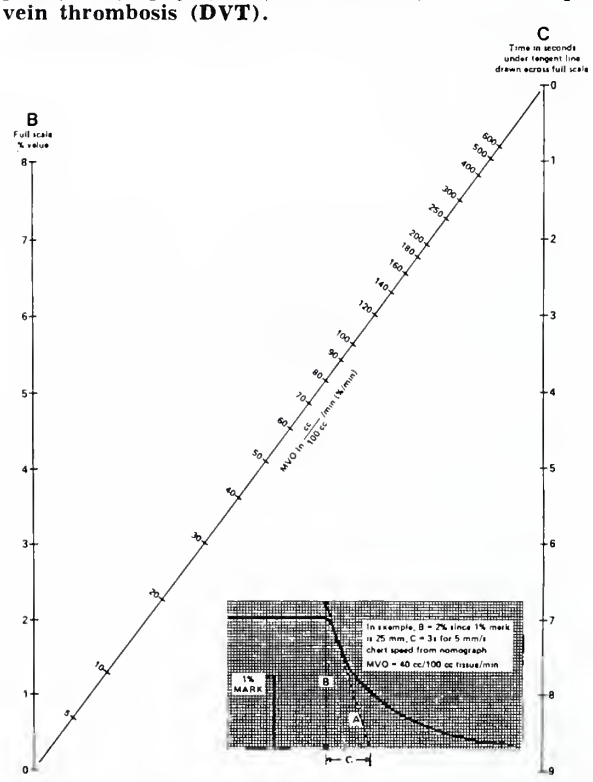

Figure 7. Nomograph for measurement of maximum venous outflow in the diagnosis of deep vein thrombosis (DVT).

Using strain gauge plethysmograph (MedaSonics), the patient lies in a supine position with the knee being tested flexed at 15 to 20 degrees. The leg is elevated with support under the thigh and foot so that the calf is 20 to 25 centimeters above the examination table. The strain gauge is positioned around the maximum girth of the calf. The gauge is connected to the plethysmograph, and a thigh pneumatic cuff is connected to an automatic cuff inflator (Figure 6). The thigh cuff is inflated to 50 millimeters Hg for a period of two minutes and then quickly deflated. With the help of Nomagraph, the maximum venous outflow (MVO) can be calculated (Figure 7).

It is desirable to repeat the procedure at least one time. Results should be comparable. The procedure should be repeated until consistent results are obtained.

Diagnostic criteria for calf outflows (MVO):

41 ± 11 cc/min/100 cc tissue (% min) — within normal limits.

12± 8 cc/min/100 cc tissue (% min) — compatible with DVT.

I-125 Fibrinogen Leg Scanning

Radioactive fibrinogen assesses the activity of the thrombotic process. One hundred microcuries of I-25 labeled human fibrinogen is injected intravenously. The circulating fibrinogen will become incorporated into sites of active thrombosis. The legs are scanned at multiple sites along the course of the deep veins. The

TABLE 8

Comparison of Cases With Normal SPG With the Venogram

Venogram	*Number of Legs*	*Per Cent*	
Normal	58	90.6%)	)98.4%
Incompetent Perforators (communicating veins)	5	7.8%)	
Deep Vein Thrombosis	1	1.6%	
Total	64		

TABLE 9

Comparison of Cases With Positive SPG With Venogram

Venogram	*Number of Legs*	*Per Cent*
Deep vein thrombosis	25	60%
Incompetent perforators (communicating veins)	15	36%
Normal	2	4%
Total	42	

radioactive counts relative to cardiac background activity are determined along each leg and compared to adjacent areas on that leg and to similar points on the opposite leg. A significant increase in count, 15 to 20 per cent relative to the same or opposite leg which persists on succeeding days, is indicative of venous thrombosis.

Discussion

Five hundred, fifty patients had venous strain gauge plethysmography testing from November, 1980, through March, 1982, at our laboratory. These patients had symptoms and signs suggestive of deep vein thrombosis. One hundred, six limbs had venograms, and 136 had I-25 fibrinogen leg scans, 94 with negative SPG and 42 with positive SPG. The results are analyzed in Tables 8, 9, and 10.

The fallibility of clinical diagnosis in cases of pulmonary emboli and venous thrombosis is approximately 50 per cent.[9]

Plethysmography involves the measurement of limb hemodynamics on the basis of changes in limb volume.[10] There are a variety of plethysmographic methods available which include the mercury, water, air, impedance and strain gauge plethysmography. All of these techniques basically are designed to measure quantitatively either the rate at which blood is drained from the leg after a brief period of mechanically induced total venous occlusion or the degree to which the thrombosis interferes with the normal changes in venous volume that accompany respiration or pneumatic compression of the thigh. Plethysmographic methods will not detect an isolated clot in the hypograstric vein, deep femoral veins or small muscular veins.

Barnes *et al.* have found the strain gauge plethysmograph to be the most useful technique to quantitate the altered venous hemodynamics in not only acute deep vein thrombosis but also in the post-phlebitic syndrome and in primary and secondary varicose veins.[7,8] If the SPG is negative, exclusion of deep vein thrombosis can usually be made; however, if the SPG is positive, either DVT or incompetent perforators (incompetent communicating veins with no thrombosis) is likely to be present (96 per cent).

TABLE 10

Comparison of Cases With Positive SPG and I-125 Fibrinogen Scan With Venogram

		Venograms		*Cases of DVT*	
Number of Cases		*DVT*	*Incompetent Perforators*	*Normal*	*Per Cent*
Positive SPG and Leg Scan	24	23	1	0	96%
Positive SPG and negative Leg Scan	18	2	14	2	11%
Total	42				

The I-125 fibrinogen leg scan effectively aids in differentiating those cases with positive SPG. When a positive SPG is combined with positive leg scan, the accuracy rate is 96 per cent true positive (23 of 24 legs). If the SPG is positive with negative leg scan, the diagnosis of incompetent perforators is most likely to occur (14 of 18 legs, or 78 per cent).

In conclusion, the SPG is a reliable test in excluding DVT (98 per cent). When combined with fibrinogen leg scan, it has a reliability rate of 96 per cent, but only 60 per cent are true positives when SPG is done alone.

Summary

This study analyzes the results of over 5,000 patients studied in our noninvasive diagnostic vascular laboratory in the last four years. These included around 3,000 patients who had noninvasive carotid testing, mainly oculoplethysmography (OPG), with 1,080 arterial leg Doppler (ALD) tests for peripheral vascular occlusive disease (PVOD), 550 venous strain gauge plethysmography (SPG) for deep vein thrombosis (DVT), and about 1,000 other miscellaneous tests.

We concluded that a combination of OPG/Gee and real-time B-image scanning was the best noninvasive testing for the diagnosis of carotid artery stenosis. Arterial leg Doppler testing was very satisfactory in the diagnosis of peripheral vascular occlusive disease. The venous strain gauge plethlysmograph was excellent in excluding cases of deep vein thrombosis.

Acknowledgments

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Tuberculosis After Jejunoileal Bypass Surgery*

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A young man underwent jejunoileal bypass surgery for morbid obesity. He later developed disseminated tuberculosis. There is increased risk of tuberculosis following this type of surgery as well as post-gastrectomy. These patients should be screened for tuberculosis prior to surgery and followed closely post-operatively for this complication.

Case Report

A white male in his early thirties underwent greater than 90-per cent jejunoileal bypass for morbid obesity in 1979. He did well, losing approximately 200 pounds (over 50 per cent of his pre-operative weight). About two years later, he noted weakness. easy fatigability, generalized arthralgias and myalgias, with nightly fevers, chills and sweats. He also unintentionally began to lose more weight. His surgeon evaluated him for lymphoma when a mediastinal mass was noted on chest x-ray. A lymphangiogram and abdominal CT scan showed diffuse lymphadenopathy. Sternotomy demonstrated a benign thymic cyst with numerous noncaseating granulomas. This tissue was not cultured. A positive purified protein derivative (PPD) was overlooked.

Approximately one year ago, the patient was admitted to West Virginia University Hospital in moderate distress and malnourished. An intermediate-strength PPD produced 25 mm of induration at 24 hours. The mediastinal mass as well as a right apical infitrate were seen on chest roentgenogram (Figure). Axillary lymph node biopsy demonstrated caseating granulomas. Cultures from both the sputum and lymph node grew Mycobacterium tuberculosis. Liver, urine and bone marrow cultures were negative.

The patient's symptoms resolved and he began to gain weight after treatment with isonicotine hydrazine (INH), ethambutol, and rifampin. Serial serum drug levels documented adequate therapy (Table).

*This paper was written while Doctor Maxwell was a resident in medicine, West Virginia University School of Medicine, Morgantown.

Discussion

Eighteen patients with tuberculosis complicating intestinal bypass surgery were reported in the literature between 1969 and 1980. This represents an incidence of one to four per cent, depending on the study,[1] and a greater than 63-fold increase (estimated) in the risk of tuberculosis over the general population.[2]

These patients more often present with extrapulmonary tuberculosis, most commonly with lymph node involvement. The symptom complex of accelerated weight loss, lymphadenopathy, and unexplained fever suggests tuberculosis. The average time to onset of symptoms following bypass is 16 months.[3] This length of time

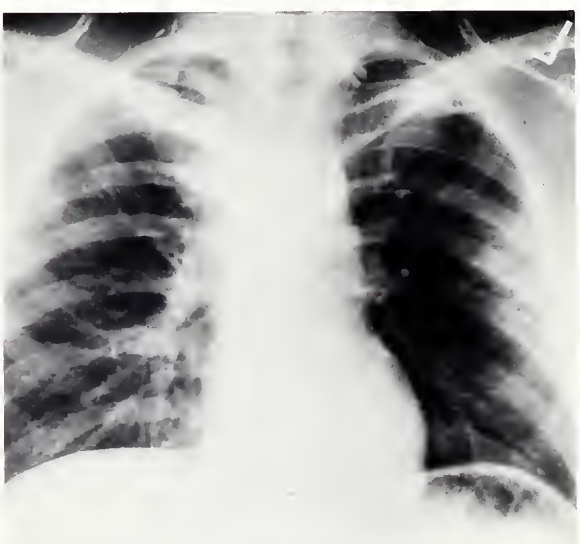

Figure. Left subclavian lymph nodes are seen with lymphangiogram contrast dye. The mediastinum is wide. The right apex and partachael area demonstrate pulmonary involvement.

TABLE
Serum Levels of Oral Antituberculosis Drugs

DRUG	INH	Ethambutol	Rifampin
DOSE	400mg	30mg/kg	1200mg
THERAPEUTIC RANGE (mcg/ml)	0.4-4.0	3-12	10-40
TIME	SERUM CONCENTRATION (mcg/ml)		
1 hr	6.5	—	—
2 hrs	—	7.55	15.4
3 hrs	—	—	11.6
4 hrs	5.2	3.17	6.2

is usually coincident with the phase of rapid weight loss which occurs post-operatively.[4]

The association of pulmonary tuberculosis after gastrectomy with malabsorption has been well-documented.[2,3] Malnutrition with weight loss and its sequelae of immunosuppression is considered an important factor in the increased susceptibility to tuberculosis.[2] Lymphocyte transformation in the presence of specific antigen in intestinal bypass patients with tuberculosis gave positive but less energetic responses than normal controls.[2]

These data suggest that these patients cannot defend themselves normally against tuberculosis, especially during the period of rapid weight loss.

The other major problem in these patients is assuring adequate therapy because of decreased absorptive surface and rapid transit. Ethambutol is absorbed from the stomach and proximal jejunum. Rifampin participates in an enterohepatic circulation with proximal absorption in the stomach with biliary excretion and jejunal reabsorption. Therefore, serum levels of these drugs should be done to document adequate therapy.[2] Our patient is only the third patient reported to have documented adequacy of treatment with serum drug levels.

Yu[3] recommends that all patients being considered for this surgery undergo intermediate PPD prior to surgery. If positive and no disease is found, he recommends one year of treatment with INH, as is done with post-gastrectomy patients.

These patients illustrate the need to be aware of the increased risk of tuberculosis following jejunoileal bypass surgery. They should receive INH prophylaxsis for one year following surgery if the PPD is positive. Finally, serum drug levels are necessary to ensure adequate therapy.

Acknowledgements

Lederle Laboratories and Merrell Dow Pharmaceuticals for performing the drug assays.

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Conservative Treatment Recommended

A large-scale study by surgeons and physicians at Houston's M.D. Anderson Hospital suggests that conservative surgery and irradiation are viable alternatives to radical mastectomy for selected patients with early breast cancer.

Writing in a recent issue of *Archives of Surgery*, Marvin M. Romsdahl, M.D., Ph.D., and colleagues report that 922 patients were followed from 1955 through 1979 in a study that compared conservation surgery and irradiation with radical or modified radical mastectomy in the treatment of minimal, stage I and stage II breast cancer.

"Disease-free survival rates at five and 10 years for patients having radical mastectomy or conservation surgery with irradiation are similar," the researchers say.

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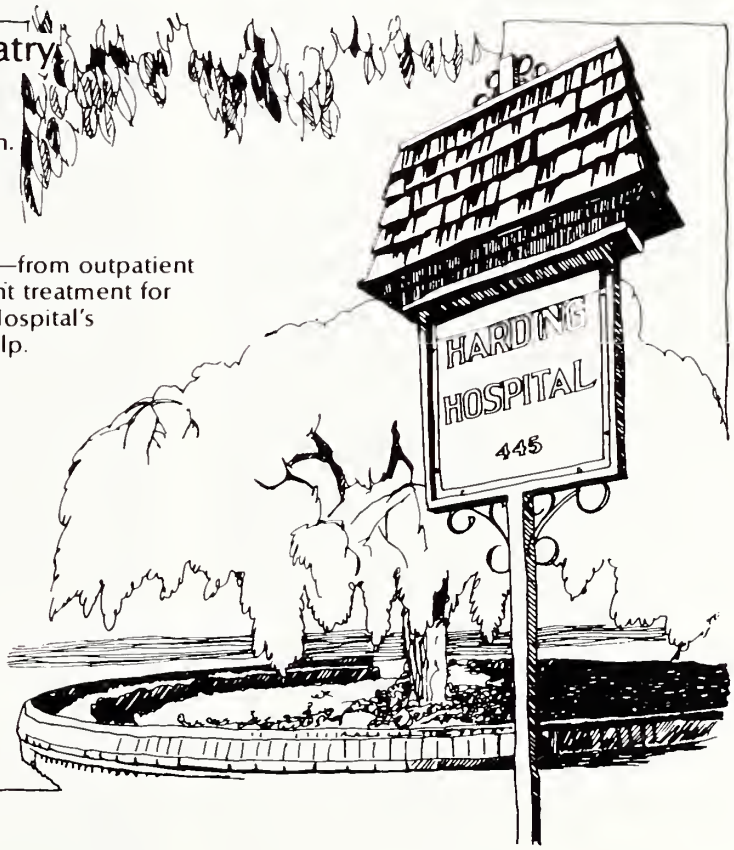


The Harding Hospital

445 East Granville Road
Worthington, Ohio 43085

George T. Harding, Jr., M.D.
Medical Director

Thomas D. Pittman, M.P.H.
Administrator

Member of Blue Cross of Central Ohio
Accredited by the Joint Commission on Accreditation of Hospitals

A message from . . .

The President

THE ROLE OF OUR ORGANIZATION

SOMETIMES in the stress of day-to-day medical practice, amid the complexities of modern-day life, we tend to lose track of the original goals and purposes of our organization. Indeed, some of us may have forgotten or never have known of them. It is refreshing and enlightening now and again to look back at our stated purposes. To this end I quote the pertinent section of our constitution.

Article II, Section 1 of the Constitution of the West Virginia State Medical Association states "the purposes of this association shall be to federate and bring into one compact organization the entire medical profession of the state of West Virginia, and to unite similar associations or societies of other states to form the American Medical Association; to extend medical knowledge and advance medical science; to promote the public health; to elevate the standards of medical education; to secure the enactment and enforcement of just medical laws; to promote the general welfare of physicians; and to enlighten and direct public opinion in regard to the problems of state medicine so that the profession shall become more capable and honorable within itself, and more useful to the public in the prevention and cure of disease and in prolonging life and adding comfort thereto."

At the risk of "preaching to those already in church," I would like to reflect for a bit on some of the stated purposes of our organization—"to bring into one compact organization the entire medical profession of the state of West Virginia." This means membership. It is important to bring all the practitioners of our profession into the membership of our Association so that we may indeed speak as one united voice. Our Association, like any other, constantly gains and loses members. New practitioners move into the state; others leave the state or retire. It is vitally important that we encourage newer practitioners and other non-members to unite with us in membership so that our Association may fulfill its purpose of representing the entire medical profession of West Virginia.

"To extend medical knowledge and advance medical science." "To promote the public health." "To elevate the standards of medical education and to secure the enactment and enforcement of just medical laws." Without an active and involved, representative Association to achieve these goals, one individual practitioner has but limited resources to use in an attempt "to promote the general welfare of physicians and to enlighten and direct public opinion —so that the profession shall become more useful to the public in the prevention and cure of disease and in prolonging life and adding comfort thereto."

Without the resources of our Association, the individual would find this an almost insurmountable task, but, paradoxically, the Association cannot survive without the resources and actions of individual members. There is a symbiosis between the organization and the actions of the individuals within that organization. One cannot survive without the other. Accordingly, as individual members, we must continue to attract other individuals to the organization to increase its strength and resources for our mutual benefit.

We members cannot rely only on our office staff to carry out all the activities needed to promote the goals of our Association. The resources of our office are many and are there for the members to use, but our six staff members cannot respond to inquiries from the press, legislature, and others, publish *The Journal,* influence all the necessary lawmakers, run the insurance program, schedule and operate the CME activities and meetings, etc., without help from us, the members. They can provide the resources but it is up to us to provide the action. If we do not, our goals will not be met. I look forward to seeing each of you at our Annual Meeting to provide that action!

Harry Shannon MD

HARRY SHANNON, M. D., *President*
West Virginia State Medical Association

The West Virginia Medical Journal

Editorials

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author shall be held entirely responsible. Editorials printed in The Journal do not necessarily reflect the official position of the West Virginia State Medical Association.

QUALITY COMMITMENT

Despite the furor, confusion and complexity of modern living, Gerald C. Kempthorne, M. D., President of the State Medical Society of Wisconsin, always returns to one fundamental premise. Despite the changing atmosphere surrounding the practice of Medicine, he recently noted, "I find physicians are continuing to do what they have always done—practice quality medicine for the patients they are committed to serve."

"Certainly, the delivery systems have changed dramatically," Doctor Kempthorne wrote in the *Wisconsin Medical Journal*. "However, I have seen no diminution in the physician's fervor in continuing the role of patient's advocate. In view of the rapidly changing scene, the one *solid* profession behind the welfare of the patient is the House of Medicine. Schemes and scenarios may come and go, but when the dust settles, the physician will be there, as usual, caring for his or her patient."

The Wisconsin President has emphasized, consistent with general thinking reflected in continuing medical education programs and otherwise, that keeping up is an important part of the profession. There is, he said, no other health caring profession which can demonstrate more effectively the advances in human health care than what we have witnessed in Medicine.

"We are now able to diagnose serious illness without dangerous invasion of the body," Doctor Kempthorne observed. "There is hardly a condition of the human body we cannot treat in one manner or another with varying degrees of success. People want expert medical care, and it has been laid at the doorstep of every patient."

"Essentially, most people want freedom from disease, and long life," he continued. "Is that an unreasonable aspiration? Only recently have people begun to do their part with efforts at wellness and prevention of disease. Until the long-term benefit from that activity arrives, society still will be faced with the need to treat disease and illness."

Touching on a theme common everywhere, and getting varying degrees of legislative and other attention, Doctor Kempthorne noted that "virtually no obstacles stood in the way of achieving the long, good life until it was finally recognized that it really does cost money to underwrite such an ambitious endeavor." He added:

"Now, the realization is upon us that optimal medical care is costly. Who wants to say that we should de-emphasize the importance of a long, healthy life? If it takes 10 per cent of the gross national product in order to assure that quality of life, is that bad, even if we could be more efficient in the system?"

Doctor Kempthorne also stressed that to malign the hospital system and physicians in America as the culprits of the escalating cost scenario is far too simple. The current preoccupation with health care costs won't mean much unless society at large decides to take an active role.

Now, let's let Doctor Kempthorne take it from here against a background of some of the thinking and legislative activity which recently has come to the front in West Virginia:

"If health care is to be optimal in all circumstances, then there will be a substantial price tag attached, despite all efforts at economizing. Will someone have the bravery to suggest that ordinary or adequate care is good enough? If we can't afford optimal care, who will suggest rationing? Can you imagine writing guidelines for limits on medical care because of the cost? Currently, it is fashionable to 'penalize' the poor by requesting a copayment for services after giving them a medical card because they couldn't afford medical care in the first place.

"Until we can 'cure' the insatiable appetite for optimal health care by all of us, we are truly facing an enigma. We (meaning our social order) have virtually encouraged all of our citizens to seek optimal care in the past. Now

we are 'hinting' that we can't afford it, and we are spending a lot of time and effort to find the cause of the problem we created in the first place.

"The current 'cost of health care' is much like a red ink jigsaw puzzle without form. There are so many parts in the faceless form that it makes it difficult and depressing to try to put it all together. Experts and ideas will come and go to solve the amorphous riddle. Whatever set of principles finally evolves, the medical profession will remain at the 'bedside' of the patient and never abandon his or her calling, despite the cry from the outside."

A heartening trend in patient care continues in West Virginia, and in fact appears to be picking up still more momentum. Fifteen of the 20 family physicians completing their residency training this summer are remaining in the state. That's 75 per cent, about the ongoing figure for that particular program.

NEW RESOURCES

Increased numbers of West Virginia University School of Medicine graduates are practicing here after completing their training. That percentage is near 50 since 1974. Early indications are that the same general pattern will develop with graduates from the Marshall University School of Medicine.

In addition, West Virginians who have been practicing or in training elsewhere are coming back in noticeable numbers. They are returning from such points as South Carolina and Texas, and going to such counties as Summers and Pocahontas.

This is the time of the year in which, across the nation, many young doctors complete residencies and enter into practice. They begin a challenging and fascinating new phase of their careers—and one which also is certain to bring some frustration and adjustment problems.

We trust, in West Virginia, that our medical communities will welcome these new colleagues, and stand ready to assist and counsel them. We need their knowledge and skills, and their movement to rural and so-called physician shortage areas, in particular, must be further encouraged.

Clearly, some of the young doctors will find that their training, heavily weighted in scientific knowledge, has left something to be desired in the social, economic, legal and political aspects of medical practice, and of the complex health care system in which they will work.

They will be faced with the specific challenge of always trying to do what is best for their patients in a very cost-sensitive health care environment.

The new doctors will find society confused about what to do about health care and its rising cost. Society wants more health care for more people and equal access for all to high quality care, but is balking at the expense.

It's important for all physicians, old and new, never to forget that their primary obligation is the historic responsibility of doctor to patient. This always must come ahead of any business or corporate obligations.

The Missouri State Medical Association, through its *Journal*, recently reminded its members that most groups appearing before the Missouri General Assembly are "single issue" in nature.

SINGLE ISSUE

These groups, despite small numbers, organize very effective campaigns to gain approval of their particular objective. They work hard to make personal contact with each representative and senator.

Physicians, meanwhile, apparently have come to believe that someone else will take care of their interests in this bothersome (legislative) area—and they are wrong, the Missouri Journal stressed.

Legislators, it added, are going to vote according to the wishes of the constituents who contact them. If physicians choose not to be heard, they won't be!

Does all this sound familiar? It should. It simply echoes what the West Virginia State Medical Association leadership has been saying over and over again. Instead of "single issue" we've used the words "single shot." But the lesson is the same.

While one particular group is working on one bill, an organization such as the Medical Association will be monitoring or dealing to some degree with 100 or more. Staff and other resources accordingly are thinly spread.

Without more and more physician interest and input, concerns of this Association and the patients for whom it is the advocate are in trouble. And as they say in Missouri, if physicians choose not to be heard, they won't be.

GENERAL NEWS

Convention Symposium To Eye Cardiovascular Disease

Cardiovascular surgery and cardiac arrhythmias will be among subjects discussed in a "Symposium on Cardiovascular Diseases" during the 116th Annual Meeting of the State Medical Association.

The speakers on the above two subjects, it was announced by the Program Committee, will be Drs. John C. Alexander, Jr., of Morgantown, whose topic will be "Cardiovascular Surgery—

John C. Alexander, Jr., M. D.

Stafford G. Warren, M. D.

An Update;" and Stafford G. Warren, Charleston cardiologist, "New Developments in the Management of Cardiac Arrhythmias."

The symposium, which also will include a paper on congestive heart failure, will constitute the second general scientific session of the convention Saturday morning, August 27.

The Annual Meeting will be held August 25-27 at the Greenbrier in White Sulphur Springs.

Doctor Alexander is Associate Professor of Surgery and Chief, Section of Cardiothoracic Surgery at the West Virginia University School of Medicine.

Doctor Warren is Clinical Professor of Medicine at WVU Charleston Division.

The Annual Meeting will open with a preconvention session of the Association's Council and the first session of the House of Delegates on Thursday morning and afternoon, August 25; and end with the second and final House session and reception for Association members and guests Saturday afternoon, and a dinner that evening (see story on page 154 for details).

Doctor Adkins to be Installed

At the final House session on Saturday afternoon, Dr. Carl R. Adkins of Fayetteville will be installed as the Association's 1983-84 President to succeed Dr. Harry Shannon of Parkersburg.

Dr. Frank J. Jirka, Jr., President of the American Medical Association, as announced previously, will address the first House session on Thursday. He is from Barrington, Illinois.

Dr. Samuel P. Asper of Philadelphia, also as announced, will deliver the keynote Thomas L. Harris address during opening exercises Friday morning preceding the first general scientific session. Doctor Asper, who is President of the Educational Commission for Foreign Medical Graduates, will speak on "Strengths and Weaknesses of the U. S. Role in International Medicine."

First Scientific Session

Friday morning speakers and topics for the first general scientific session, a "Symposium on Sexually Transmitted Diseases," will be:

"Syphilis and Gonococcal Infections" — Dr. Edmund C. Tramont (colonel, U. S. Army Medical Corps), Chief, Infectious Diseases, Department of Bacterial Diseases, Walter Reed Army Institute of Research, Washington, D.C.; and Associate Professor of Medicine and Coordinator (Chief), Division of Infectious Diseases, Uniformed Services University of the Health Sciences Medical School, Bethesda, Maryland; "Non-Luetic, Non-Gonococcal Venereal Diseases" — Dr. Lee P. Van Voris, Chief, Infectious Diseases, and Epidemiologist at Hamot Hospital, Erie, Pennsylvania (formerly Associate Professor of Medicine, Marshall University School of Medicine);

"Transmissible Diseases of the Gay Patient" — Dr. George J. Pazin, Associate Professor of Medicine, University of Pittsburgh; and "Sexual Mores in the 1980s" — Dr. Jack L. Summers, Chairman, Department of Urology, Akron (Ohio) City Hospital, and Professor, Depart-

ment of Urology, Northeastern Ohio Universities College of Medicine, Akron.

In addition to the House and general sessions, the Annual Meeting agenda will include breakfast, luncheon and other programs arranged by specialty societies and sections, many of which also will provide scientific discussions.

Scientific Exhibits

Scientific exhibits, again to be housed in Eisenhower Hall, will be open from 1 to 5 P. M. on Thursday, and from 8:30 A. M. to noon on Friday and Saturday. The exhibits will be listed in the August issue of *The Journal*. In order to provide convention registrants with ample opportunity to visit the exhibits, coffee breaks for that purpose have been scheduled during the general scientific session Friday and Saturday mornings. The scientific sessions will be held in the theater, which adjoins Eisenhower Hall.

Doctor Alexander came to WVU in 1982 from Cornell University, where he was Assistant Professor of Surgery.

A native of Durham, North Carolina, he was graduated from Duke University, and received his M. D. degree in 1971 from the University's School of Medicine. He was the recipient of an Early Internship at Duke in 1971-72, completing his residency there and at the Surgery Branch, National Cancer Institute, National Institutes of Health, Bethesda, Maryland.

Doctor Alexander was a Teaching Scholar at Duke in 1979-80 before going to Cornell.

University of Rochester Graduate

Doctor Warren is certified in internal medicine and cardiology, and is a Fellow of the American College of Cardiology. He was graduated from Davidson (North Carolina) College, did a year of graduate work at Wesleyan University in Middletown, Connecticut, and then entered the University of Rochester School of Medicine, receiving his M. D. degree in 1969.

He interned at the University Hospital of Cleveland, and completed postgraduate studies there and at Duke University.

Doctor Warren is a member of the active staff at Charleston Area Medical Center (CAMC), and was the 1975 recipient of a research grant from Medical Associates (CAMC) for a CPK isoenzyme study.

He is the author or co-author of some 13 scientific publications.

The Auxiliary to the State Medical Association, with Mrs. Richard S. Kerr of Morgantown the current President, as usual will hold its meeting in conjunction with that of the Association.

1983 Program Committee

Members of the 1983 Program Committee are David Z. Morgan, M. D., Morgantown, Chairman; Doctor Adkins; Jean P. Cavender, M. D., Charleston; Michael J. Lewis, M. D., St. Marys; Kenneth Scher, M. D., Huntington, and Roland J. Weisser, Jr., M. D., Morgantown.

The official convention program, and information concerning remaining speakers and other details will be provided in the August issue of *The Journal*.

Saturday Convention Dinner Added To Schedule

As noted in the June issue of *The Journal*, the Medical Association's Annual Meeting Program at the Greenbrier will be enhanced this year by a black-tie dinner to honor outgoing and new leaders of the Association and Auxiliary.

This dinner, a "by-ticket only" innovation, is scheduled for Saturday evening, August 27. It will be held in Chesapeake Hall and will be the convention's last event, following the second and final House of Delegates meeting.

The dinner will enable the Association and Auxiliary leadership to offer comments, in a largely informal style, they feel pertinent as to the organizations' activities, objectives and the like. Invited guests will include the Presidents and spouses of the American Medical Association, and neighboring states represented each year.

It might be necessary for some of those who have made their hotel reservations to review them in the light of plans they might revise to attend the Saturday dinner.

Current plans call for dinner tickets to be on sale at the Association and Auxiliary registration desks, beginning on Thursday morning, August 25. It will be necessary to provide the Greenbrier with an attendance guarantee by late on Friday, August 26.

At this writing, planning for the dinner is continuing, and the membership will be kept advised as other details fall into place. Meanwhile, if any physicians already have plans to attend, and desire to advise the Association office, P. O. Box 1031, Charleston 25324, that advance information would be helpful.

Continuing Education Activities

Here are the continuing medical education activities listed primarily by the West Virginia University School of Medicine for part of 1983, as compiled by Dr. Robert L. Smith, Assistant Dean for Continuing Education, and J. Zeb Wright, Ph. D., Coordinator, Continuing Education, Department of Community Medicine, Charleston Division. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of The Journal.)

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the Morgantown, Charleston and Wheeling campuses. Further information about these may be obtained from: Division of Continuing Education, WVU Medical Center, 3110 MacCorkle Avenue, S. E., Charleston 25304; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 2000 Eoff Street, Wheeling 26003.

Sept. 3, Morgantown, Treatment Options in Arthritis

Sept. 9-10, Morgantown, Ob/Gyn Teaching Days

Sept. 14, Charleston, Advances in Hypertension

Regularly Scheduled Continuing Education Outreach Programs from WVU Medical Center/ Charleston Division

Buckhannon, St. Joseph's Hospital, first-floor cafeteria, 3rd Thursday, 7-9 P. M. — July (summer break).

Cabin Creek, Cabin Creek Medical Center, Dawes, 2nd Wednesday, 8-10 A. M. — July 13, "Headaches," A. L. Poffenbarger, M. D.

Gassaway, Braxton Co. Memorial Hospital, 1st Wednesday, 7-9 P. M. — July 6, "The Pharmacology of Hypertension Management," Stephen Grubb, M. D.

Aug. 3, "Diagnosis of Pulmonary Disorders," Dominic Gaziano, M. D.

Madison, 2nd floor, Lick Creek Social Services Bldg., 2nd Tuesday, 7-9 P. M. — July 12, "Approach to the Peripheral Vascular Patient," Ali F. AbuRahma, M. D.

Oak Hill, Oak Hill High School (Oyler Exit, N 19) 4th Tuesday, 7-9 P. M. — July (summer break).

Welch, Stevens Clinic Hospital, 3rd Wednesday, 12 Noon-2 P. M. — July (summer break).

Whitesville, Raleigh-Boone Medical Center, 4th Wednesday, 11 A.M.-1 P.M. — July-August (summer break)

Williamson, Appalachian Power Auditorium, 1st Thursday, 6:30-8:30 P. M. — July (summer break).

Alzheimer's Disease Autopsies Needed, Researcher Urges

A California pathologist calls for more autopsies of Alzheimer's disease victims to assist researchers investigating this puzzling and devastating disorder.

"Despite its past anonymity, Alzheimer's disease is a killer that strikes over 1.5 million Americans and causes about 50 per cent of all nursing home admissions, at a staggering annual cost of $20 billion," said George G. Glenner, M. D., in an editorial in a recent issue of *Archives of Pathology and Laboratory Medicine*.

The University of California, San Diego, researcher said the National Alzheimer's Disease Brain Bank at his institution emphasizes the need for autopsies to obtain adequate material for research investigations on the disease, as well as to offer families an accurate diagnosis. Since a genetic component for the disease has been suggested, families can gain helpful information through accurate diagnosis of the cause of death of aged parents who had symptoms resembling Alzheimer's disease.

Thyroidectomy Speaker

Dr. Romeo Y. Lim of Charleston spoke on "Emergency Thyroidectomy for Tracheal Obstruction" at the New York University "Otolaryngology Update '83" in June in New York City. Doctor Lim is Clinical Associate Professor of Otolaryngology — Head and Neck Surgery at West Virginia University, and an active staff member of the Eye and Ear Clinic of Charleston.

HEALTH SCIENCES LIBRARY

Reference Manual Offered By Cancer Society

Cancer Manual, a cancer reference text, now is available from the West Virginia Division of the American Cancer Society.

The 444-page manual provides a fundamentally pragmatic approach to the problems of patients with specific cancers. It also includes many contemporary issues such as those dealing with psychosocial aspects, sexuality, nutrition, hospice concepts, and the role of nurses and social workers.

As such. the Cancer Society commented, this book should be of interest to practicing physicians, interns, residents, medical students, nurses, and all others involved in cancer care. It can be used as a desk-top reference for history and physical examination techniques, diagnostic principles, and epidemiology of cancer sites. Information on pathology, the various treatment modalities, and rehabilitation techniques also are covered.

The book can be obtained by sending a check for $4, payable to American Cancer Society, West Virginia Division, Inc., to the Society at 240 Capitol Street - Suite 100, Charleston 25301.

Review A Book

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal,* Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication.

Current Medical Diagnosis and Treatment, 1983, edited by Marcus A. Krupp, M. D.; and Milton J. Chatton, M. D. 1130 pages. Price $24. Lange Medical Publications, Los Altos, California 94022. 1983.

General Ophthalmology, 10th Edition, by Daniel Vaughan, M. D.; and Taylor Asbury, M. D. 407 pages. Price $17. Lange Medical Publications, Los Altos, California 94022. 1983.

Neuroanatomy: An Atlas of Structures, Sections, and Systems, by Duane E. Haines, Ph.D., Professor of Anatomy, West Virginia University School of Medicine, Morgantown. 212 pages. Price $19.50. Urban & Schwarzenberg Medical Publishers, 7 East Redwood Street, Baltimore, Maryland 21202. 1983.

Review of Medical Physiology, 11th Edition, by William F. Ganong, M. D. 643 pages. Price $20. Lange Medical Publications, Los Altos, California 94022. 1983.

Doctor Santrock Elected WVU Alumni Head

Dr. David A. Santrock of Charleston recently was elected the 82nd President of the West Virginia University Alumni Association during 1983 alumni/commencement weekend activities.

Doctor Santrock, an orthopedic surgeon, received a B. S. degree in 1963 from WVU, and his M. D. degree in 1967 from the University's School of Medicine. He has been a member of the Alumni Association Executive Council since 1980.

Elected Vice President was Lucy Bowers Eilson, 1950, of Beckley, civic and alumni leader.

Dr. Stanley J. Kandzari of Morgantown, first row, left, was installed as President of the West Virginia Chapter, American College of Surgeons at its spring meeting held at the Greenbrier. Other officers shown are, from left, front row, Sharon Bartholomew, Morgantown, Executive Secretary, and Drs. Catalino B. Mendoza, Jr., Clarksburg, President Elect, and William R. McCune, Martinsburg, Councilor; second row, Drs. Roger E. King, Morgantown, First Vice President, and William E. Gilmore, Parkersburg, Councilor; third row, Drs. Billie M. Atkinson, Parkersburg, and James A. Coil, Jr., Huntington, Councilors. Dr. Herbert G. Dickie, Jr., of Wheeling is Governor, and Dr. Alvin L. Watne of Morgantown, Secretary-Treasurer.

1983 Scholarship Winners Named By Committee

The West Virginia State Medical Association has awarded to another four state students four-year scholarships to the West Virginia University and Marshall University Schools of Medicine. Each scholarship is worth $1,500 annually, or $6,000 total.

Here are the 1983 selections of the Association's Committee on Medical Scholarships, as announced by the Committee Chairman, John Mark Moore, M. D., of Wheeling, after an annual Committee meeting early in June in Bridgeport:

William M. Skeens of Huntington, who will enter MU School of Medicine this fall; and Debra Sue Hinzman of Harrisville, Susan Marie Sypolt of Terra Alta, and John L. Stanley of Fayetteville, who will be first-year students at the WVU School of Medicine.

Married and the father of two children, Skeens received a B. S. degree in chemistry at MU this past spring. He is the son of Mr. and Mrs. William C. Skeens, Jr., of Barboursville.

Biology Degree

Miss Hinzman, the daughter of Mr. and Mrs. Luther H. Hinzman of Harrisville, was graduated this spring from WVU with a B. S. degree in biology.

Miss Sypolt received a B. A. degree in chemistry this spring at WVU. She is the daughter of Mr. and Mrs. Robert Sypolt of Terra Alta.

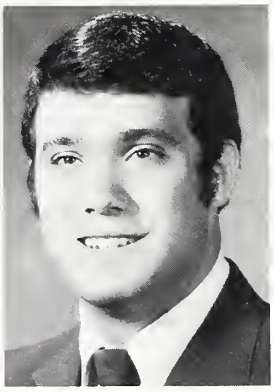
Stanley is the son of Mr. and Mrs. Albert L. Stanley of Fayetteville. He earned a B. S. degree in biology in December, 1982, from West Virginia Wesleyan.

The new awards bring to 68 the number of scholarships granted by the Medical Association since its program began in 1958. One scholarship was granted annually until 1962, when the number was increased to two. In 1974, the Association began awarding four scholarships annually.

William M. Skeens

Debra Sue Hinzman

Susan Marie Sypolt



John L. Stanley

Financial need is the major factor considered by the Committee on Medical Scholarships. Under provisions of agreements they sign, scholarship recipients must agree to practice in West Virginia for four years following graduation and completion of postgraduate training and military obligations.

Over the years, about 75 per cent of the scholarship recipients who have completed their training have entered practice in West Virginia, a result in line with the program objective encouraging additional young physicians to establish careers here.

Other members of the Committee on Medical Scholarships are Drs. R. L. Chamberlain of Buckhannon, Marshall J. Carper of South Charleston, Robert D. Hess of Clarksburg, Thomas J. Holbrook of Huntington, James T. Hughes of Ripley, Kenneth G. MacDonald, Sr., of Charleston, William L. Mossburg of Fairmont, an earlier scholarship recipient, and David Z. Morgan of Morgantown.

Scholars Program Recipient

Dr. Eric Sawitz of the Marshall University School of Medicine is one of 20 physicians chosen this year for the Robert Wood Johnson Foundation Clinical Scholars Program. The program began July 1.

He will spend two years studying health communications and medical computing at Stanford University and the University of California at San Francisco. He will receive a complete scholarship plus a stipend for his study and research.

MEDICAL LIBRARY

Results In Radial Keratotomy Study Reported Good

A first prospective evaluation of radial keratotomy reports good short-term results for the new operative procedure aimed at correcting myopia.

Radial keratotomy is a surgical procedure in which a series of incisions is made in the cornea from the outer edge toward the center in spoke-like fashion. It is done to correct an error of refraction that causes rays of light entering the eye to be brought to a focus in front of instead of on the retina.

"Although the predictability of radial keratotomy is controversial, this study has shown that radial keratotomy can be effective for reducing myopia over a range of approximately 10 diopters," report Peter N. Arrowsmith, M. D., of Nashville's Parkside Surgery Center, and colleagues in a recent issue of *Archives of Ophthalmology.*

Caution in U. S.

The researchers point out that ophthalmologists have been cautious in judging the safety and efficacy of radial keratotomy since its introduction in the United States in 1978. Opinions about the procedure have ranged from mild endorsement to confidence about its effectiveness in reducing myopia and in its predictability.

"We report the results of one carefully performed and monitored prospective evaluation of radial keratotomy," the researchers say. "The emphasis of this report is on short-term efficacy and safety."

The study was conducted consecutively on 156 eyes of 101 patients. Before surgery, mean spherical equivalent was -5.0 diopters, and uncorrected distance acuity was 20/200 or worse in 96 per cent of the eyes.

Six-Month Results

Six months after surgery, distance acuity was 20/20 in 43 per cent and 20/40 or better in 73 per cent of the eyes. The mean change in spherical equivalent was +4.8 diopters.

"Visual acuity and refractive results were best for eyes in which preoperative myopia was less than 3.0 diopters," the researchers say. "In these eyes, 92 per cent achieved 20/40 or better uncorrected distance acuity six months after surgery, and 61 per cent had 20/20 acuity or better."

Medical Meetings

July 31-Aug. 4—National Spinal Cord Injury Assoc., Chicago.

Aug. 1-3—International Society for Sexually Transmitted Disease Research, Seattle.

Aug. 1-5—Am. Venereal Disease, Seattle.

Aug. 22-24—Spinal Cord Regeneration & Recent Developments (Am. Paraplegia Society), Las Vegas.

Aug. 25-27—116th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

Sept. 7-10—Peripheral Vascular Disease Symposium (Saint Anthony Hospital), Columbus, OH.

Sept. 29-Oct. 1—Am. Assoc. for the Surgery of Trauma.

Sept. 29-Oct. 2—Am. Society of Internal Medicine, San Francisco.

Oct. 2-5—Am. Neurological Assoc., New Orleans.

Oct. 5-8—Am. Thyroid Assoc., New Orleans.

Oct. 7-8—AMA Congress on Occupational Health, Beachwood, OH.

Oct. 16-21—Am. College of Surgeons, Atlanta.

Oct. 22-27—Am. Academy of Pediatrics, San Francisco.

Oct. 23-26—Am. College of Gastroenterology, Los Angeles.

Oct. 23-27—Am. College of Chest Physicians, Chicago.

Oct. 24-27—Am. College of Emergency Physicians, Atlanta.

Oct. 26-30—Am. Academy of Child Psychiatry, San Francisco.

Nov. 6-9—Scientific Assembly, Southern Medical Assoc., Baltimore.

Nov. 7-9—Am. Medical Women's Assoc., Dearborn, MI.

Nov. 18-22 — Gerontological Society of Am., San Francisco.

Nov. 30-Dec. 1—Am. College of Chemosurgery, Chicago.

1984

Jan. 27-29—17th Mid-Winter Clinical Conference, Charleston.

March 17—Annual Meeting, W. Va. Affiliate, American Diabetes Assoc., Wheeling.

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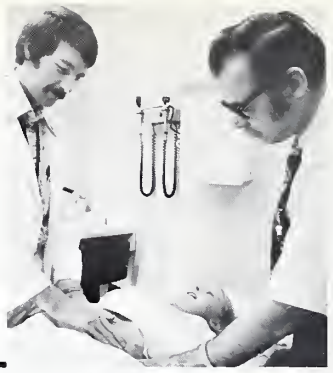
WVU Medical Center
–News–



Compiled from material furnished by the Medical Center News Service, Morgantown, W. Va.

How Should You Diagnose, Treat Borderline Hypertension?

There is some disagreement among doctors concerning just what constitutes mild elevation of blood pressure and how it should be treated.

"The controversy comes from the fact that we don't really know where the fine dividing line between normal blood pressure and hypertension is," said Dr. Stanley R. Shane, Professor and Interim Chairman of Medicine.

The most important issue, he continued, in determining whether to treat borderline hypertension is the presence or absence of other risk factors—primarily family history of high blood pressure, obesity, diabetes and abnormal blood cholesterol or triglyceride values. Smoking and a sedentary lifestyle along with high stress or driving-type personality are believed to contribute to elevated pressures, particularly when combined with the other risks.

Related to Body Weight

"Blood pressure is distinctly related to body weight," he stated. "We don't understand why. There's a fair amount of data that's been looked at with no clear-cut relationship. But often if people reduce their weight, sometimes by just 10 pounds, their blood pressure will be lowered and they can avoid medication.

Doctor Shane said he believed physicians might justify not treating patients with borderline pressure elevations and no other risk factors with the realization that the actual average pressure is probably lower than that.

"But on the other hand, that says a great deal about the role of stress," he explained. "If a person's blood pressure rises because of a visit to the doctor, is there a similar response to other stressful situations?

"I've seen patients who are on a sackfull of medicine—and their blood pressure is still not well controlled—who will decide to leave a job they've found stressful for years. It's striking to see their blood pressure return to normal. In fact, often I have to discontinue some of the medication."

Early treatment in most cases of borderline or moderate hypertension should include stress management, weight control and salt restriction, Doctor Shane said. Also needed is development of a good health maintenance program with exercise.

These instructions are seemingly easier for the physician to give than for the patient to follow, in many cases.

Patient Compliance Difficult

"Part of patient compliance is a matter of education," Doctor Shane said. "It's very difficult dealing with hypertension because hypertension doesn't cause pain or discomfort. If hypertension were associated with pain, you'd have no problem with compliance.

"You always have to speak to patients in terms of future benefits—not today, not even tomorrow, but sometimes as much as 10-20 years down the road. Hypertension has its effects over the long term. It's not an immediate thing, so it's always difficult to talk to a patient about following a program or taking medication to prevent something that's going to happen 20 years from now."

Dr. Ludwig Gutmann Elected Neurologists' Officer

Dr. Ludwig Gutmann, Chairman of the Department of Neurology, has been named President Elect of the Association of University Professors of Neurology.

Doctor Gutmann has been Secretary-Treasurer for the past four years. Association membership includes all chairmen of departments of neurology in the United States.

Doctor Gutmann, who has headed the WVU Neurology Department since 1970, is a graduate of Princeton University, and received his medical degree from Columbia University. He was named to the National Board of Medical Examiners last fall.

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Third-Party News, Views and Program Concerns

Workers' Compensation Fee Schedule Planned

Workers' Compensation Commissioner Gretchen O. Lewis has advised medical providers that the Workers' Compensation Fund is in the process of developing a medical fee schedule and updating its computerized claim system.

A provision of state statute stipulates that "the commissioner shall establish, and alter from time to time as he (or she) may determine to be appropriate, a schedule of the maximum reasonable amounts to be paid to physicians, surgeons, hospitals or other persons, firms or corporations for the rendering of treatment to injured employees . . . "

In her letter to providers, Ms. Lewis had these other comments:

"To insure prompt and correct payment to the providers and to permit our monitoring of the services rendered, we find it necessary to require the proper CPT Code, in addition to a narrative description of the treatment rendered, when submitting fee bills to this office.

"This has been a requirement for some time, but has not been strictly enforced. However, effective July 1, 1983, we will no longer accept any fee bills without the proper CPT Codes.

"Current Procedural Terminology (Fourth Edition) code books may be purchased from 'Order Department OP-041, American Medical Association, P.O. Box 10946, Chicago, IL 60610'." These CPT Code Books are presently available at the cost of $23.45 each, including postage and handling."

'Squeal Rule' Still Wanted By Administration

Early this year, judges in both Washington and New York blocked the controversial "squeal rule" which requires federally-funded family planning clinics to notify parents when their teenagers receive prescription contraceptives.

But, in May the Reagan Administration went back to the Washington, D.C., Appeals Court to urge reinstatement of the rule.

Government appeal of the second suit, filed by New York State's Attorney General, was sent to be heard in New York in June, the American Medical Association reported.

Action Postponed in West Virginia

In West Virginia, an Appeals Court postponed action on a third suit after the Washington and New York rulings.

In Utah, a federal judge has blocked a state "squeal rule" until a full hearing is held.

Attorneys for the Administration say that a 1981 amendment passed by Congress was designed to make parents more involved in their children's sexual decision-making. Simply encouraging teenagers to talk to their parents has not helped reduce the number of teenage pregnancies, they say.

"It is absolutely clear that the Secretary of Health and Human Services had the authority to issue the regulations challenged in this case," argued Justice Department lawyer Carolyn B. Kuhl before the Washington, D.C., judge. "The family cannot participate in an activity that it does not know is taking place . . . "

But family planning groups charge that the "squeal rule" invades a teenager's right to privacy and violates patient-physician confidentiality. Furthermore, there is little basis for the government's contention that notification would protect the health of teenagers; prescription contraceptives pose few problems to women under age 18, they say.

AMA Against 'Squeal Rule'

The AMA and the American College of Obstetricians and Gynecologists, siding with the family planning groups, contend that a notification rule will scare teenagers away from family planning clinics and lead to an upsurge in adolescent pregnancies. "Teens are five times more likely to die from pregnancy and childbirth than from the use of oral contraceptives," Dr. Luella Klein, ACOG's Vice President, said at a press conference earlier this year.

Obituaries

V. R. ANUMOLU, M. D.

Dr. V. R. Anumolu, Fairmont internist, died on May 31 when fire burned the Myrtle Beach. South Carolina, beachhouse in which he was sleeping. He was 37.

Doctor Anumolu's wife, Sarojini Anumolu, also died in the fire.

Doctor Anumolu was a former member of the West Virginia State Medical Association.

A native of India, he had practiced in Fairmont for approximately seven years.

* * *

SAM MILCHIN, M. D.

Dr. Sam Milchin, retired Bluefield general practitioner, died on May 31 at his home. He was 72.

A native of Richmond. Virginia, Doctor Milchin was graduated from the University of Richmond. and received his M. D. degree in 1935 from the Medical College of Virginia.

He began practice in Bishop, Virginia, and Jenkinjones, West Virginia, moving to Bluefield in 1953. He then opened his office in Bluefield. Virginia. Residents of both Bluefields and the surrounding areas were among his patients.

Upon his recent retirement, the community honored him with a dinner tribute.

Doctor Milchin was a World War II Navy veteran.

He was a member of the Mercer County Medical Society, West Virginia State Medical Association and American Medical Association.

Surviving are the widow and two daughters, Mrs. Tom Garrett and Susan Milchin. both of Richmond.

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County Societies

CENTRAL WEST VIRGINIA

Dr. Frederick C. Whittier of Morgantown was the guest speaker for the spring meeting of the Central West Virginia Medical Society on May 5 in Jacksons Mill at the Deerfield Country Club.

Doctor Whittier, Chairman of the Department of Nephrology, West Virginia University Medical Center, discussed hypertension and nephrology.

The Society approved two scholarships of $225 each to Camp Kno-Koma, and a sustaining donation of $50 to the American Medical Association's Medical Student Section.—Greenbrier Almond, M. D., Secretary-Treasurer.

* * *

WESTERN

The Western Medical Society met on May 10 in Ripley at the McCoys Motor Lodge.

The host for the evening was The John Hancock Insurance Company, whose representative, Tom Leadbetter, was the guest speaker. His topic was "Personal Financial Planning."

The Society will adjourn for the summer, with the next meeting scheduled on September 13 at Roane General Hospital in Spencer.—Ali H. Morad, M. D., Secretary-Treasurer.

* * *

PARKERSBURG ACADEMY

The Parkersburg Academy of Medicine met on March 9 at the Parkersburg Country Club.

The guest speaker was Robert McHenry, Trust Officer of Parkersburg National Bank, whose topic was "Estate Planning, Wills and Trust."

The Academy met again on April 13 at the Parkersburg Country Club. Robert Shade, M. D., Associate Professor of Medicine, Division of Gastroenterology, University of Pittsburgh, was the guest speaker. His subject was "Peptic Ulcer Disease-GI Bleeding."

The Academy approved a donation of $225 for Camp Kno-Koma.

The Academy met again on May 11 at the Parkersburg Country Club. The guest speaker was Don Sensabaugh, an attorney with the Charleston firm of Kay, Casto and Chaney, whose topic was "Medical Malpractice."

(continued on page xxiii)

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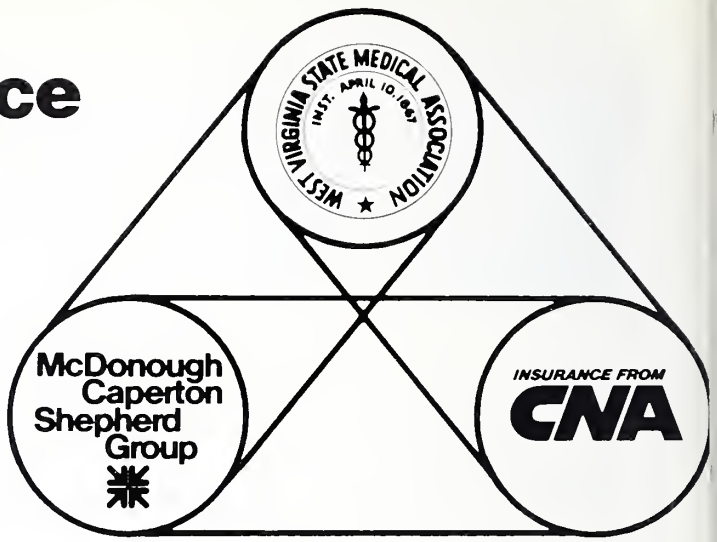

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The West Virginia Medical Journal

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Effect of Ethrane Supplementation On Intrapulmonary Shunting In Dogs Anesthetized With Nitrous Oxide And Morphine

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LAWRENCE M. LAVINE, M. D.
Assistant Professor of Anesthesiology, University of Chicago School of Medicine, Chicago, Illinois

This study involving eight mongrel dogs was undertaken to determine whether pulmonary oxygenation is adversely affected by the supplementation of enflurane to nitrous narcotic anesthesia under normal states of cardiovascular and respiratory function.

The results indicate that under normal states of respiratory and cardiovascular function, supplementation of enflurane to morphine-N_2O-O_2 anesthesia in response to painful stimuli has no adverse effect on pulmonary oxygenation.

Intrapulmonary shunting and arterial pO_2 were unchanged from baseline values ($p>.05$) except at 45 minutes when intrapulmonary shunting was actually decreased ($p<.05$).

General anesthesia, by producing decreased FRC, increased small airway closure, microatelectasis and altered ventilation/perfusion ratios, causes regional alveolar hypoxia. This regional alveolar hypoxia is partially compensated by pulmonary hypoxic vasoconstriction, which redistributes blood flow from hypoxic alveoli to normoxic alveoli.[1] Since the first description of this phenomenon,[2] numerous studies have been performed in man and animals determining that hypoxic pulmonary vasoconstriction is relatively spared by narcotics and nitrous oxide, but may be inhibited by halothane or enflurane.[3,4,5,6,7]

To insure adequate pulmonary oxygenation, some anesthesiologists routinely increase the FiO_2 of inspired gases when they supplement nitrous-narcotic anesthesia with enflurane. The purpose of this study was to determine whether this practice is really necessary.

Eight mongrel dogs, weighing 18-22 kg., were given an infusion of four ml/kg of D5RL, and then were infused with four ml/kg/hour of D5RL during the experiment. The dogs were anesthetized with four mg/kg sodium pentothal, given one mg/kg succinylcholine and intubated with a cuffed endotracheal tube. Anesthesia was maintained with 66 per cent N_2O, 33 per cent O_2, and one half mg/kg morphine sulfate. The dogs were given 0.4 mg/kg curare and mechanically ventilated maintaining a pCO_2 of 35-40 torr. An arterial line and a Swan Ganz catheter were introduced. Blood pressure and heart rate were continuously monitored.

Baseline Data

One hour after induction of anesthesia, the following baseline data were obtained: systemic arterial pressure, arterial blood gas, mixed venous PO_2, cardiac output (via thermodilution method), and heart rate. Blood removed for sampling was immediately replaced with an equal volume of D5RL. After baseline data were obtained, the tails of the dogs were clamped. In response to this stimulus, enflurane was administered to maintain the mean arterial pressure at 80 per cent of its preclamping value.

Additional sets of data were collected five minutes, 15 minutes, and 45 minutes after tail-clamping.

The intrapulmonary shunt was calculated from the following equation:

$$\text{shunt} = \frac{Cc' - Ca}{Cc' - Cv}$$

Cc' is the oxygen content in the pulmonary end-capillary blood.

Ca is the oxygen content of arterial blood.

Cv is the oxygen content of mixed venous blood.

Cc' is calculated from the "ideal" alveolar Po_2 (itself calculated from the Alveolar Air Equation), the hemoglobin content of the blood, and the relationship between PO_2 and saturation of hemoglobin (the oxygen dissociation curve).

Data Compared

The data obtained for each time interval were compared with the corresponding pre-clamping values by use of the paired T-test. As expected, the mean values of the arterial pH, pCO_2, cardiac output, and heart rate were unchanged from their control values for all time periods ($p>0.05$). Mean arterial pressure was approximately 80 per cent of its control value for all time periods.

Of significance were the results obtained for the arterial pO_2 and the intrapulmonary shunt. The mean arterial pO_2 was unchanged for all time periods ($p>0.05$). The intrapulmonary shunt was unchanged from its control value in 40 per cent of the dogs, and was decreased by 50 per cent of its baseline value in the other 60 per cent of the dogs. Overall, the average intrapulmonary shunt was slightly decreased at the five- and 15-minute time intervals, and was significantly reduced at the 45-minute time interval ($p<0.05$).

In conclusion, it appears that under normal states of respiratory and cardiovascular function, supplementation of enflurane to morphine-N_2O-O_2 anesthesia in response to painful stimuli has no adverse effect on pulmonary oxygenation.

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Dopamine-Modulating Drugs, Amenorrhea-Galactorrhea And Neuropsychiatric Illnesses

PAUL E. FRYE, M. D.
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The properties and clinical uses of drugs that alter dopamine function in the brain are discussed in relationship to hypotheses in psychoneuroendocrinology. Established and potential treatments in the three related medical disciplines are discussed. The role of dopamine and its receptors in psychiatric illnesses, movement disorders, and amenorrhea-galactorrhea is emphasized. Treatment in one area may result in altered function in other systems in which dopamine has a role.

Drugs that facilitate or inhibit dopaminergic transmission in the central nervous system (CNS) are used in many areas of medicine. Modifying the activity of dopaminergic systems in the CNS has psychiatric, neurologic and endocrinologic effects. The purpose of this paper is to discuss the drugs, the hypotheses, and the clinical aspects of dopamine modulation.

Phenothiazines, such as chlorpromazine (Thorazine), were introduced in this country as antipsychotics three decades ago: subsequently, physicians have used effectively a number of neuroleptic compounds in the treatment of schizophrenia and affective disorders. Amphetamines and other CNS stimulants have been used as antidepressants and anorexic agents. They are presently accepted treatment for narcolepsy and attention deficit disorders.

The usefulness of levodopa (Sinemet) in Parkinsonism was followed by the discovery of additional anti-Parkinson agents among the ergot alkaloids. These compounds have a structural similarity to dopamine.[1] Chemical modification has produced related compounds with less vasoconstrictor and uterine effects than are common in the naturally-occurring ergot alkaloids. These derivatives include bromocriptine, which retains the property of dopamine facilitation and the ability to inhibit prolactin secretion. American clinicians recently have begun using bromocriptine mesylate (Parlodel) to treat hyperprolactinemia.[2] In Europe, bromocriptine has found application in a variety of endocrine disorders, including acromegaly.[3]

Pharmacologic properties of the opiate alkaloid apomorphine, including its potency for inducing emesis, have precluded its use in Parkinsonism, but it has been an important compound in research in the pharmacology of dopaminergic systems. Apomorphine is presumed to be a "direct" stimulator of dopamine receptors, because its effects are not altered by drugs that inhibit the production or storage of intrinsic dopamine.[4] (Thus it is appropriately called a dopamine *agonist*, while amphetamines and other compounds that *facilitate* transmission via intrinsic dopamine are not.)

Hypotheses in Psychiatry, Neurology, and Endocrinology

Dopamine is released into synapses in the nigrostriatal, mesolimbic, and tuberoinfundibular (or tuberohypophyseal) systems. It has various effects as a result of interaction with post-synaptic receptors, and also acts in direct inhibitory feedback by way of autoreceptors on the cell of origin. Dopamine-modulating drugs vary in their direct or indirect effects on presynaptic and postsynaptic receptor activity. Whether the presynaptic (inhibitory) effect will predominate is believed to depend on concentration for some drugs. For example, low doses of apomorphine result in predominantly presynaptic activity and, thus, an inhibitory influence (in contrast to its property of dopamine agonism at higher doses).[4,5,6] Biochemical findings that implied increased turnover of dopamine during neuroleptic treatment led Carlsson and Lindqvist to speculate, in 1963, that the mode of action of antipsychotic drugs is blockade of dopamine receptors.

Additional data subsequently have supported and modified a "dopamine hypothesis" for the etiology of schizophrenia.[8] The hypothesis is that schizophrenia is a result of excessive activity of dopaminergic neural systems. Previously well patients occasionally develop neuropsychiatric syndromes as a result of toxic effects of ingested substances. Drugs known to facilitate dopamine have been associated with psychiatric syndromes resembling schizophrenia or affective disorder. Paranoid ideation, delusions, hallucinations, inappropriate behavior, disorders of thinking, and affective disturbances have been documented following use of levodopa, amphetamine, co-

caine, methylphenidate (Ritalin), bromocriptine, and lergotrile.[9,10] The occurrence of such syndromes in persons presumably without psychiatric illness gives impetus to the assumption that ingestion of these drugs would exacerbate the illness of persons with schizophrenia, which by hypothesis means vulnerable dopaminergic neural systems. Stimulants and ergot alkaloids do increase psychotic symptoms in some (but not all) schizophrenics.[8,11] This is compatible with the dopamine hypothesis of schizophrenia.

Altered dopaminergic function also has been postulated in attempts to explain the etiology of affective disorders. Randrup and Braestrup interpret data and cite reviews supporting a dopamine hypothesis of depression.[12] Various authors have reported evidence of a dopaminergic mechanism in mania.[12,13]

Parkinsonism, Receptor Changes

The association of degeneration of dopaminergic systems in the substantia nigra with Parkinsonism led to a search for a dopamine precursor.[8] The success of levodopa in treatment of this crippling illness and the mimicking of Parkinson's disease as an adverse effect of neuroleptics that are potent dopamine antagonists support the assumption of decreased dopaminergic function in the etiology of Parkinsonism.

Prolonged alterations of neurotransmitter function result in receptor changes. Tardive dyskinesia involves rhythmic, involuntary movements of the orofacial, limb or trunk muscles, and it is associated with neuroleptic treatment.[14] In order to explain the occurrence of tardive dyskinesia during or following neuroleptic drug use, an increased sensitivity, similar to the type seen following denervation, has been postulated to occur in central dopamine receptors.[15] In this model, prolonged blockade of receptors leads to supersensitivity; withdrawal of the blocking agent is followed by a rebound effect of greater transmission than normal. Bunney *et al.* reviewed evidence suggesting that lithium can block or modify the development of supersensitivity in CNS dopamine receptors.[16]

A number of physiologic and non-physiologic processes can elevate prolactin levels and produce amenorrhea and galactorrhea. Dopamine-modulating drugs have pronounced effects on prolactin: antagonism of dopamine results in hyperprolactinemia, while dopamine agonists lower prolactin levels.[2] Primary control of prolactin secretion is by tuberoinfundibular dopaminergic neurons that terminate at the hypophyseal portal system; regulation occurs by release of a prolactin-inhibitory factor that is probably dopamine itself.[3]

Dopamine appears to provoke human growth hormone (HGH) release under normal conditions. Levodopa, apomorphine, and bromocriptine increase HGH secretion in normal persons; however, in patients with acromegaly, the same medications paradoxically decrease excessive growth hormone levels. Several authors have speculated on the role of dopamine in regulating HGH, but as yet no explanation for this phenomenon is fully satisfactory.[3]

Clinical Aspects of Dopamine Modulation

The use of neuroleptics, stimulants, and anti-Parkinson agents to modify transmission in dopaminergic systems is well-established. Their adverse effects include toxic psychoses, drug-induced movement disorders, and amenorrhea-galactorrhea. Most physicians are skilled in early recognition and treatment of extrapyramidal reactions to neuroleptics. On the other hand, amenorrhea, galactorrhea, and adverse effects on sexuality generally have gone without emphasis. Screening for these troublesome and unintended results may reveal problems in as many as one woman in two, or one in 10 men.[17]

Amenorrhea and galactorrhea have been associated with neuroleptics since shortly after the introduction of the phenothiazines in the 1950s.[18] For all neuroleptics of each chemical family, nearly all patients have elevation of plasma prolactin within three days.[17,19] Apostolakis *et al.* reported a study of 260 patients: 50 per cent of females and 10 per cent of males, taking psychotropic drugs known to cause hyperprolactinemia, developed some degree of inappropriate lactation.[20] A higher than normal frequency of amenorrhea has been reported among patients with untreated psychiatric disorders.[18] As a result, it is difficult to conclude what proportion of amenorrhea during neuroleptic treatment to attribute to drug effect. Nonetheless, elevated prolactin is clearly a major cause of amenorrhea, whether or not it is accompanied by galactorrhea.[2]

Bromocriptine mesylate has been approved by the U. S. Food and Drug Administration for treatment of amenorrhea-galactorrhea of various etiologies, excluding demonstrable pituitary tumor; more recently, it was approved for postpartum inhibition of lactation. Conversely, experience with dopamine agonists for treatment of endocrine disorders is limited. Because we are unable to forecast which patients are at risk for exacerbation of psychiatric symptoms, it is

difficult to justify the use of bromocriptine or other dopamine agonists as the initial treatment for neuroleptic-induced amenorrhea-galactorrhea. (Alternatives with less risk are discussed below.)

When bromocriptine must be prescribed for patients with a history of schizophrenia or affective disorder, low initial dosage and small increments thereafter are preferable in order to minimize psychiatric complications. Frequent assessment of mental status is critical. If neuropsychiatric disturbance does occur, it appears to be reversible, at least during the early stages of bromocriptine treatment.[21] The large number of physiologic and pathologic processes that can cause hyperprolactinemia mandates that all patients with amenorrhea-galactorrhea have a thorough evaluation prior to starting bromocriptine. This includes endocrine studies and tomographic roentgenograms of the sella turcica.[22]

When a patient develops amenorrhea-galactorrhea during neuroleptic treatment and has no indication of another etiology, the physician has several options for an initial approach. Elevation of prolactin by neuroleptics is dose-related and quickly reversible.[19] Thus, one choice is to lower the dose of neuroleptic. (Using the lowest effective dose also has been advocated to produce the least interference in cognitive function and to reduce the risk of neuroleptic-induced (tardive) dyskinesia.[23]) Another option is to change medications since each neuroleptic raises prolactin to a different degree.[19]

Psychiatric Applications

Despite the importance of caution in clinical use of bromocriptine and other dopamine facilitators for patients with psychiatric illness, experimental uses of drugs that increase dopaminergic function suggest potential psychiatric applications of this property. Bromocriptine, apomorphine, and piribedil (all dopamine agonists) have been reported useful in mania.[13] Recent cases have appeared in the literature reporting the use of methylphenidate in the treatment of depression among elderly patients for whom standard treatments were contraindicated.[24]

Steiner and Carroll reviewed the literature supporting the utility of bromocriptine in premenstrual dysphoria syndrome.[25] When Tamminga *et al.* gave apomorphine in low doses to test the presynaptic dopamine inhibition hypothesis, nine of eighteen schizophrenic patients had 20- to 50-per cent reduction of symptoms (compared to placebo): some stopped hallucinating; some lost their delusions.[6] Friedhoff reported success using levodopa to treat tardive dyskinesia; his hypothesis is that supersensitive dopamine receptors are "retuned" to lower sensitivity by brief overstimulation and resultant compensation.[15]

Conclusion

Dopamine blockade has brought major advances in psychiatric treatment. Other modifications of dopaminergic transmission in the CNS are established treatment in neurology, psychiatry, and endocrinology, or offer potential benefits on these frontiers. These advances have promoted new understanding of brain function; yet, the adverse effects of dopamine modulation remain.

Psychiatrists will continue to utilize dopamine-blocking neuroleptics when indicated, until better treatment is found. It is important that primary care physicians be aware that neuroleptic drugs are a common cause of amenorrhea and galactorrhea, and that treating with dopamine agonists carries risks that are not eliminated simply because the patient is in remission or is taking neuroleptic medication.

When physicians evaluate patients with acute mental status changes, drug-induced facilitation of dopaminergic transmission must be included in the differential diagnosis. For example, a person with bromocriptine-induced organic delusional syndrome (toxic organic brain syndrome) must be differentiated from "schizophrenic." Early intervention may prevent the detrimental interpersonal, intrapsychic, biochemical, and social-vocational changes that can result from the internal events and external manifestations of psychosis or from stigmata that follow diagnostic labeling. Alertness to this distinction may avert unnecessary suffering.

Editor's Note: Here are the generic drugs and trade names (in parentheses) to which reference is made in this manuscript: bromocriptine mesylate (Parlodel); chlorpromazine (Thorazine); levodopa (Sinemet); and methylphenidate (Ritalin).

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Drug Prevents Hemorrhages In Injured Eye

RESEARCHERS at theUniversity of Illinois Eye and Ear Infirmary, Chicago, have demonstrated conclusively the safety and efficacy of a heretofore neglected treatment to prevent recurring hemorrhage in an injured eye.

Their report in a recent issue of *Archives of Ophthalmology* shows that aminocaproic acid administered in precisely calculated doses can reduce significantly the incidence of secondary hemorrhage after blunt (nonperforating) trauma to the eye. The drug, a synthetic amino acid, works by inhibiting dissolution of blood clots and consequent reopening of ruptured ocular blood vessels, according to John J. McGetrick, M. D.

116th ANNUAL MEETING

of the

West Virginia State Medical Association

The Greenbrier

AUGUST 25-27, 1983

PLAN NOW TO ATTEND

A message from . . .

The President

HANGING TOGETHER

THIS is my last President's Page. Dr. Carl Adkins of Fayetteville will be installed as your President at our Annual Meeting this month. While this has been a fantastic year and has meant more, personally and professionally, than I can express, I nonetheless confess to some small sense of relief that I will be passing the gavel, especially to such a capable person. During the past year, I discussed in these pages issues that I felt were important to call to your attention, such as improving communication, involvement in the political process, cost containment, malpractice tort reform, efforts in caring for the medically needy and the role of our organization. While I am sure that there have been some disagreements, I have been encouraged by the many positive comments I have heard.

For my last message, I would like to address an issue that is, in my view, a potential cause for concern. I am concerned about the possibility of increasing fragmentation of our profession into smaller, limited-interest specialty groups. These groups sometimes seem to have a very narrow sphere of interest, and may not be as willing to take a broader view of what is best for our patients and for Medicine in general.

As a urologist, I am well aware of the importance of the point of view of the specialist or subspecialist, but the broader view may be required in these times. Numerous outside pressures, such as governmental economic constraints, third-party payor intervention and the continuing malpractice crisis climate, are threatening the foundations of our free-enterprise, individual doctor-patient relationship, the basis for the best medical care in the world. We must not forget that we are all doctors first, and specialists second. This is not a reflection of a "circle the wagons" mentality or in response to a perceived threat by any group. It is a realistic appraisal of problems potentially facing us. At a time when severe economic constraints are being imposed on health care by outside forces, we in Medicine—united—must continue to stand firm for what we believe in: quality—the best possible care for the patient at the lowest possible cost. If we fragment ourselves into smaller groups with conflicting interests, then we may lose some of the influence we can yield as a united group for the ultimate benefit of our patients.

There is nothing wrong with differences of opinion and candid, blunt discussion. This is very crucial and needed, but if such discussion reaches the point of dissension and discord, and sets group against group or specialist against generalist, this serves neither the best interests of our patients nor of Medicine. There are legitimate differences of opinion and outlook among groups of specialists, and even groups of physicians within those specialties. The place to bring these different viewpoints together is through the framework of our State Medical Association and of the AMA. There, honest differences of opinion can be aired, conflicting ideas resolved and a consensus reached. There is no doubt that united we will have more influence for the benefit of our patients than many smaller groups can achieve.

These are trying times for the profession of Medicine, and many changes are in sight. This is no time for "business as usual" or limited self-interest. We need innovative and imaginative ways to deal with these changes and to preserve the quality of care we have worked so hard to achieve. In the words of Ben Franklin from our historical past, "Gentlemen, we must all hang together, or most assuredly, we shall all hang separately."

I look forward to seeing you all at our Annual Meeting to air your views and opinions; to make your comments; to share your ideas, and finally, to participate in reaching a consensus which will become the policy for the West Virginia State Medical Association. See you at the Greenbrier!

HARRY SHANNON, M. D., *President*
West Virginia State Medical Association

The West Virginia Medical Journal

Editorials

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author shall be held entirely responsible. Editorials printed in The Journal do not necessarily reflect the official position of the West Virginia State Medical Association.

Physicians must communicate "among ourselves, with our patients, with the media and the Legislature," Harry Shannon, M. D., said a year ago in assuming the Presidency of the West Virginia State Medical Association.

He set some other guidelines for his year in office, too. The public must be re-educated to the fact that the vast majority of physicians care first about their patients. The state must have a strong Board of Medicine because "if we intend to show the public we are as concerned about quality of care as indeed we are, then we must demonstrate that concern."

POSITIVE YEAR

Harry Shannon has carried those messages, and many more, into every corner of the state this past year—and has done so effectively. The media consistently has picked up his thoughts from the President's Page in *The Journal* and further broadcast them to the reading, listening and viewing public.

Have all his visions become reality? No, and that simply is an impossible thing to expect over the short period of 12 months. But Carl R. Adkins, M. D., is ready in the wings to pick up on most of these major themes, and build further on them, in his year ahead.

The past couple of years have brought a new continuity in the office of President, with those who recently have served involved in detailed exchange of ideas and objectives with those coming up the Association's leadership ladder. Never in the 116-year history of the organization has this been more important.

Doctor Shannon clearly has learned many things as he has trudged from his practice in Parkersburg to Weirton in the north; McDowell, Mingo and Mercer counties in the south; Jefferson and Berkeley in the east, and Cabell and Mason to the west.

He's learned that there *are* physicians deeply interested in the Association, and what it's trying to do. He's encouraged more involvement of all physicians, and has particularly urged that they speak out about their concerns and their own goals and values.

The more lines of communication "we can open," he said last August, "the easier it will be to resolve any differences and to achieve our goal of the highest quality of care for our patients in West Virginia."

What critical tasks still lie ahead? There are increasing numbers every year in this age of rapid technological advance, a growing physician population with eager young doctors with their own views and values—and the constantly broadening pressures upon Medicine and those it serves from the general arena of government and bureaucracy.

Within the Association, communication needs much additional work. So do short and long-

Harry Shannon, M. D.

range planning; membership recruitment and services; more effective and sophisticated risk management programs, and a year-around approach to legislative affairs.

The year has brought significant progress. Further tightening and development of accreditation for community hospital continuing medical education programs have underlined the fact that West Virginia has one of the better such efforts anywhere. Work in the area of professional liability insurance coverage has been intensified.

Doctor Adkins, as is the case with each new President, will bring his own ideas and objectives into the picture, along with a commitment to those already in place. He will add some unique expertise in the field of business administration and management, a commodity most significant in the light of current and prospective economic conditions.

The Association has grown significantly with Doctor Shannon's dedication and intense desire to serve its membership and the public of this state. Positions relative to quality care and the basic theme that the Association must exist first for the good of the patient have been strengthened.

From the staff standpoint, and that of others in the leadership, the year has been a most enjoyable one. There might be some feeling of frustration as to what didn't quite get done, but that in no way detracts from the overall 1982-83 record.

Under Doctor Adkins' leadership the membership can feel comfortable that the same atmosphere of concern, dedication and intensity will continue. The challenge to the membership will be to respond to that leadership. We are confident it will.

PUBLIC TRUST

As the American Medical Association recently has noted, results of three separate polls related to regulation and the jurisdiction of the Federal Trade Commission over Medicine have contained some interesting messages for the profession.

Among other things, the polls showed that the public image of the AMA improved by two per cent between 1981 and 1983, with 72 per cent of the public indicating a great deal or a fair amount of confidence in the AMA's ability to propose fair and workable health policies.

Significantly, all other groups covered by the surveys, including the federal government, congressional committees and labor unions, reflected declines in public confidence.

Most important, however, the polls showed an increase in public preference for a local versus national approach to the regulation of Medicine. This preference had become a majority viewpoint as of March of this year.

Along these same general lines, public opinion also apparently had crystallized in favor of a locally based approach to planning and development of health care policies. This trend was strongest among highly educated young people.

In earlier polls, the public view was somewhat poorly defined when those surveyed were asked if they had more confidence in policies developed by the government at the national level, or by officials and groups at the local level.

This public expression of confidence in local health planning and regulation can't be stressed too heavily in the face of the many forces and trends at work today. Physicians in particular are placed under even greater pressure to measure up to what the public expects.

That's why every effort and measure of support must be put forth to make agencies like the West Virginia Board of Medicine viable, effective and credible organizations. Physicians, in day-to-day dealings with individual patients and the public in general, must have a keen awareness of the trust and confidence placed in them.

Professional and effective review programs toward assurance of the highest quality of care probably have never been more important. These programs can be done best by doctors, and should be so structured.

We never have suggested that there is a particular or magic formula for such things as patient rapport and professional conduct and responsibility. Physicians know full well the importance of such components which must be a part of their practice.

But the heat, if you will, is on all professionals in ever increasing degree. That's obvious in legislative halls, in the sprawling administrative bureaucracy and anywhere else you might want to look.

That's why it is most encouraging to know that the public still feels self-regulation of physicians, rather than state or federal controls, is best. This is a public trust that must be accommodated. The alternatives are obvious, and NOT in the best interest of patients and the public.

GENERAL NEWS

Congestive Heart Failure Convention Subject

Dr. Warren T. Anderson, Morgantown cardiologist. will speak on "The Management of Congestive Heart Failure" during the 116th Annual Meeting of the State Medical Association.

Doctor Anderson, Clinical Associate Professor of Cardiology at West Virginia University School of Medicine, will talk during a "Symposium on Cardiovascular Diseases" which will constitute the second general scientific session on Saturday morning, August 27.

Warren T. Anderson, M. D.

The convention will be held August 25-27 at the Greenbrier in White Sulphur Springs.

The announcement of Doctor Anderson's paper by the Program Committee completes arrangements for the combined business and scientific event.

A recently-announced development, an innovation this year, will be a black-tie dinner on Saturday evening honoring outgoing and new officers of the State Medical Association and the Auxiliary. The "by-ticket only" dinner, the final event in the three-day schedule, also is expected to be attended by the Presidents and spouses of the American Medical Association and neighboring states represented each year.

475 Expected to Attend

Some 475 physicians, spouses and others are expected to attend the convention, with the schedule to include: two sessions of the Association's House of Delegates; two general scientific sessions; addresses by the AMA President, Dr. Frank J. Jirka, Jr., of Barrington, Illinois, and Dr. Samuel P. Asper of Philadelphia, President of the Educational Commission for Foreign Medical Graduates; a Saturday afternoon reception for Association members and guests; and the dinner Saturday evening, as noted.

There will be some 20 scientific exhibits for viewing by conventioneers.

About 18 affiliated societies, sections and committees of the Association, and other medical groups also will have business and scientific sessions on Friday and Saturday, many in the form of breakfast and luncheon meetings.

See the official program and related articles in this issue of *The Journal* for specific convention activities and speakers.

Doctor Adkins to be Installed

Dr. Carl R. Adkins of Fayetteville, during the second House session on Saturday, will be installed as Association President to succeed Dr. Harry Shannon of Parkersburg.

Doctor Jirka will address the first House session Thursday afternoon, and Doctor Asper will

Carl R. Adkins, M. D.

deliver the keynote Thomas L. Harris Address during the opening exercises Friday morning.

The first general scientific session, a "Symposium on Sexually Transmitted Diseases," will follow the opening exercises Friday morning.

The scientific session speakers, some of whom also will give talks at the affiliated society and section meetings, have been announced in previous issues of *The Journal*. As noted, they are listed in the official program appearing in this issue.

Doctor Shannon, a urologist, will deliver his Presidential address at the second House session on Saturday afternoon. Doctor Adkins, the incoming President, is in emergency medicine at Raleigh General Hospital in Beckley.

Doctor Anderson came to Morgantown in 1977 from Washington, D.C., where he was Clinical Instructor in the Department of Medicine at Georgetown University (1971-77), and completed a cardiology fellowship at Walter Reed Army Medical Center (1971-73).

Certification

He is certified by the American Boards of Internal Medicine and Cardiovascular Disease, and is a Fellow of the American College of Cardiology, American College of Physicians, and Council of Clinical Cardiology.

Doctor Anderson was graduated from Virginia Military Institute, and received his M. D. degree in 1967 from Temple University. He served his internship and residency at Letterman General Hospital in San Francisco.

Convention Timetable

The first general scientific session will follow 9 A. M. opening exercises on Friday, August 26. The Saturday session will begin at 9:30 A. M.

The first session of the House of Delegates will be on Thursday afternoon, August 25, beginning at 2:30. The second session will be on Saturday afternoon beginning at 3:00.

Luncheon For Past Presidents

A luncheon honoring Past Presidents of the West Virginia State Medical Association will be held at the Greenbrier on Friday, August 26, during the 116th Annual Meeting.

Dr. John B. Markey of Charleston, immediate Past President, will preside, and invitations have been extended to all the Association's Past Presidents.

The scientific exhibits, again to be housed in Eisenhower Hall, will be open from 1 to 5 P. M. on Thursday, and 8:30 A. M. to noon on Friday and Saturday. The exhibits are listed elsewhere in this issue of *The Journal*.

The Association's Council will hold a pre-convention meeting at 9:30 A. M. Thursday.

Dinner Tickets on Sale

Tickets for the Saturday evening dinner will be on sale at the Association and Auxiliary registration desks, beginning on Thursday morning, August 25. It will be necessary to provide the Greenbrier with an attendance figure by late on Friday, August 26.

The Annual Meeting of the Auxiliary to the State Medical Association, with Mrs. Richard S. Kerr of Morgantown the current President, as usual will hold its meeting in conjunction with that of the Association. The official Auxiliary program also appears in this issue of *The Journal*.

Nominating Committee To Meet On Friday, August 26

The State Medical Association's Committee on Nominations will hold a 5 P. M. meeting on Friday, August 26, in the Washington Room of the Greenbrier.

Under a 1980 By-Laws amendment, the Committee will submit to the House of Delegates at least two nominees for the following offices: Vice President and Treasurer, and Delegate and Alternate to the American Medical Association. Only the name of one nominee will be necessary for the President Elect.

Association By-Laws also provide that nominations may be made from the floor for these offices, to be filled by the House in balloting at its final session on Saturday, August 27, the final day of the Association's 116th Annual Meeting.

Dr. Stephen D. Ward of Wheeling will serve as Chairman of the Committee on Nominations, with other members to include: Drs. Antonio S. Licata of Weirton, Roland J. Weisser, Jr., of Morgantown, Nabal B. Giron of Romney, Cordell A. de la Pena of Clarksburg, John A. Mathias of Buckhannon, Joseph T. Skaggs of Charleston and T. Keith Edwards of Bluefield.

Continuing Education Activities

Here are the continuing medical education activities listed primarily by the West Virginia University School of Medicine for part of 1983, as compiled by Dr. Robert L. Smith, Assistant Dean for Continuing Education, and J. Zeb Wright, Ph. D., Coordinator, Continuing Education, Department of Community Medicine, Charleston Division. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of The Journal.)

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the Morgantown, Charleston and Wheeling campuses. Further information about these may be obtained from: Division of Continuing Education, WVU Medical Center, 3110 MacCorkle Avenue, S. E., Charleston 25304; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 2000 Eoff Street, Wheeling 26003.

Sept. 3, Morgantown, Treatment Options in Arthritis*

Sept. 9-10, Morgantown, Ob/Gyn Teaching Days*

Sept. 14, Charleston, Advances in Hypertension

Sept. 16-17, Charleston, Advanced Trauma Life Support Course

Oct. 1, Morgantown, Issues in Geriatric Medicine*

Oct. 5, Charleston, Gastroenterology Update

Oct. 14, Ophthalmology Conference

Oct. 15, Morgantown, Common Problems in Nephrology*

Oct. 28-29, Morgantown, Fourth Diagnostic Ultrasound Conference

Oct. 29, Charleston, Oncology Seminar

Nov. 3-5, Morgantown, Ninth Annual Hal Wanger Family Practice Conference*

Nov. 11-12, Morgantown, Fourth Sports Medicine Symposium*

**Held in conjunction with WVU home football game.*

Regularly Scheduled Continuing Education Outreach Programs from WVU Medical Center/ Charleston Division

Buckhannon, St. Joseph's Hospital, first-floor cafeteria, 3rd Thursday, 7-9 P. M. — Aug. (summer break).

Cabin Creek, Cabin Creek Medical Center, Dawes, 2nd Wednesday, 8-10 A. M. — Aug. 10, "Common Eye Emergencies," Robert O'Connor, M. D.

Gassaway, Braxton Co. Memorial Hospital, 1st Wednesday, 7-9 P. M. — Aug. 3, "Diagnosis of Pulmonary Disorders," Dominic Gaziano, M. D.

Madison, 2nd floor, Lick Creek Social Services Bldg., 2nd Tuesday, 7-9 P. M. — Aug. 9, "Approach to the Peripheral Vascular Patient," Ali F. AbuRahma, M. D.

Oak Hill, Oak Hill High School (Oyler Exit, N 19) 4th Tuesday, 7-9 P. M. — Aug. (summer break).

Welch, Stevens Clinic Hospital, 3rd Wednesday, 12 Noon-2 P. M. — Aug. (summer break).

Whitesville, Raleigh-Boone Medical Center, 4th Wednesday, 11 A. M.-1 P. M. — Aug. (summer break).

Williamson, Appalachian Power Auditorium, 1st Thursday, 6:30-8:30 P. M. — Aug. (summer break).

Sept. 1, "Rational Use & Cost Containment in Antibiotic Therapy" (speaker to be announced).

Convention Exhibits Site Eisenhower Hall

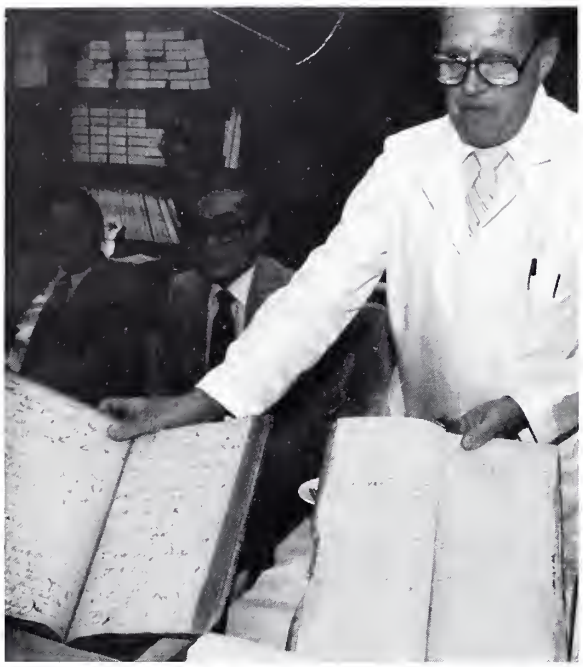
Members, spouses and others are urged to view the scientific exhibits which will be on display during the State Medical Association's 116th Annual Meeting at the Greenbrier in White Sulphur Springs.

The exhibits will be located in Eisenhower Hall, on the Shop Floor and adjacent to the theater. Exhibit hours will be from 1 to 5 P. M. on Thursday, August 25, and from 8:30 A. M. to noon on Friday and Saturday.

Coffee breaks during the scientific sessions of the convention Friday and Saturday mornings in the theater will be provided for visiting the exhibits.

State Diabetes President

Dr. Bruce S. Chertow of Huntington recently was elected President of the American Diabetes Association, West Virginia Affiliate. Doctor Chertow is Professor of Medicine and Chief, Section of Endocrinology at Marshall University School of Medicine.



Medical journals once belonging to Dr. Jessee Bennett, pioneer eighteenth century surgeon, are displayed by Dr. John M. Grubb, obstetrician-gynecologist in Point Pleasant (Mason County). It is reported that Doctor Bennett performed the first cesarean section in America in Virginia in 1794. He later moved to Mason County where he died and is buried. The old journals were shown by Doctor Grubb during a recent meeting of the Mason County Medical Society in Point Pleasant.

'Specialty For All Ages' AAFP Annual Meeting Theme

The Miami Beach Convention Center will be the site of the 35th annual convention and scientific assembly of the American Academy of Family Physicians (AAFP) October 10-13.

Delegates from the West Virginia Chapter, AAFP, will be Drs. L. Dale Simmons of Clarksburg and Joseph A. Smith of Dunbar.

This year's theme, "Family Practice, a Specialty for All Ages," highlights the family physician's capability of managing the entire family's health care.

Paul Harvey, radio, TV and newspaper commentator, will keynote the scientific program at 1:30 P. M., Monday, October 10, at the Convention Center.

Other lectures include "Life Styles and Stress," "Acquired Immune Deficiency Syndrome (AIDS)," and "Diet and Obesity."

This year's program offers 12 educational activities and more than 100 practical topics specifically designed to acquaint family physicians with the latest medical advances. Some of the topics are breast mass, fractures in children, care and conditioning of the athlete, fetal monitoring, and aspects of aging.

The Congress of Delegates, AAFP's governing body, will convene prior to the Assembly to conduct official business. The 112 delegates will meet October 8-10 at the Fontainebleau Hilton, Assembly headquarters.

Nearly 700 family physicians will receive the degree of Fellow of the AAFP Tuesday, October 11, at the Theater of the Performing Arts in Miami Beach.

Officers and Directors of the West Virginia Gastrointestinal Society were named at its annual meeting held recently in Clarksburg. They are, from left, Drs. Sidney B. Jackson, Clarksburg, board member; Donald E. McDowell, Morgantown, Secretary-Treasurer; Catalino B. Mendoza, Clarksburg, retiring President; Duane D. Webb, Huntington, President; Ronald D. Gaskins, Morgantown, President Elect; and William O. McMillan, Jr., and Eric P. Mantz, both of Charleston, board members.

State Medical Association Lists Names of New Members

The following is a list by component societies of new members of the West Virginia State Medical Association elected from January 1 through June 30, 1983:

Boone

Ernest Yutiamco ..... Madison

Brooke

Richard Bombach ..... Wheeling

Cabell

Ijaz Ahmad ..... Huntington
S. Ahmad Ettehadieh ..... "
John P. Gearhart ..... "
Douglas Glover ..... "
Colette Gushurst ..... "
Roger G. Kimber, Jr. ..... Hamlin
Jayshri Mody ..... Huntington
Alvaro Paz ..... "
Tully Roisman ..... "
Robert C. Touchon ..... "
C. Danny Waldrop ..... "
William E. Wheeler ..... "

Central West Virginia

Thomas La Mar Stahly ..... Summersville

Eastern Panhandle

Ronald J. Crisp ..... Martinsburg
Edward E. Volcjak ..... "

Fayette

O. P. Gosien ..... Oak Hill
Eleanor Navarro ..... Montgomery
Dante R. Oreta ..... Charleston

Greenbrier Valley

Malcolm S. Harris ..... Union
Thomas F. Mann ..... Ronceverte
Dorris A. Ragsdale ..... "
Lynn N. Smith ..... "
Lois Speiden ..... "
Haven N. Wall ..... Lewisburg
Robert L. Wheeler ..... Ronceverte

Harrison

Charles F. Chong ..... Clarksburg
John J. Crossen ..... "
Amar N. Gulati ..... "
James A. Knost ..... "
Saad Mossallati ..... "
Susan W. Miller ..... "
Michael C. Robinson ..... "
James Weinstein ..... "

Jefferson

Michael R. P. Atherton ..... Ranson
John A. Stefano ..... "

Kanawha

Antonio R. Cafoncelli ..... Charleston
Stephen Paul Cassis ..... "
Glenn Crotty, Jr. ..... "
Paul H. Derboven ..... Tornado
Kenneth M. Harman ..... Charleston
Henry Levenson ..... "
Robert Thomas Linger, Jr. ..... "
Stephen E. Perkins ..... South Charleston
Thomas Douglas Rapp ..... Ripley
Raymond O. Rushden ..... Charleston
Happy Verma ..... "
Maheshwer B. Verma ..... "
David Owen Wright ..... "

Logan

Boppana Rao Prasada ..... Whitman

Marion

Agnes M. Franz ..... Fairmont
Sitha Rama Swamy Katragadda ..... "
Harry G. Kennedy, Jr. ..... "
Tom Turner ..... "

Marshall

Romeo Bihag Tan ..... Moundsville

Mason

Suresh Kumar Agrawal ..... Point Pleasant
Mel P. Simon ..... " "
Richard L. Slack ..... " "

Mercer

R. M. Bhagat ..... Bluefield
Robert B. Miller ..... "
John G. Murray, Jr. ..... Cool Ridge
Charles M. Olmsted ..... Bluefield
Stephen P. Poolos ..... "
Meryl A. Severson ..... Princeton

Mingo

Pastor C. Gomez ..... Williamson
C. H. Yajnik ..... "
Sutin Srisumrid ..... South Williamson, KY
Subhash A. Vyas ..... Williamson

Monongalia

Patricia Bayless ..... Morgantown
Priscilla Gilman ..... "
John P. Griffiths ..... "
Janis Leigh Hurst ..... Fairmont
Marian Swinker ..... Morgantown
Paul Parker Williams ..... "

Ohio

Vincente P. Almario ..... Wheeling
Michael W. Blatt ..... "
Rajai T. Khoury ..... "
Donald John Mirate ..... "
William L. Noble ..... "
Frederick J. Payne ..... "
Ahmad Rahbar ..... "
John Gregory Tellers ..... "

Parkersburg Academy

Juanito Aya-Ay ..... Grantsville
James Dauphin ..... Parkersburg
Van B. Elliott ..... "
John Michael Foster ..... "
Purisima Guerrero ..... "
R. B. Henthorn ..... "
Richard Johns ..... "

Potomac Valley

Henry G. Taylor ..... Franklin

Preston

Robert A. Gregg ..... Kingwood
Patricia Haase ..... Masontown
J. E. Swanton ..... Reedsville

Raleigh

Mario C. Ramas ..... Beckley
Cirilo Z. Villanueva ..... "

Tygart's Valley

Robert M. Holley ..... Clarksburg
Rex B. Kare ..... Grafton
Robert W. O'Donnell ..... Elkins

(Continued On Next Page)

Student Members

R. David Allara	WVU, Morgantown
John David Angotti	WVU, Clarksburg
David R. Ayers	MU, Huntington
Danny C. Blankenship	WVU, Morgantown
A. Thomas Bundy	" "
Brent Wilson Chapman	" "
Lee C. Drinkard	WVU, Wheeling
Michael B. Edmond	WVU, Monongah
Jackson L. Flanigan	MU, Martinsburg
Daniel Scott Frame	WVU, Morgantown
Jo Ann Goldbaugh	" "
Kimberly Carol Irwin	" "
Jocelyn L. James	WVU, Charleston
Nancy Joseph	MU, Huntington
Maurice D. Kinsolving	WVU, Morgantown
Susann Lea Lovejoy	MU, Huntington
Michele Maroon	WVU, Morgantown
Gary Lance Matheny	WVU, Charleston
Mark Robert McGinnis	WVU, Morgantown
Steven G. McLaughlin	" "
Kenneth F. McNiel	MU, Huntington
William R. Marchand	WVU, Morgantown
Debra Jean Panucci	" "
Lakshmikumar Pillai	" "
R. Michael Simpkins	" "
Teresa Lynn Skidmore	" "
Donna J. Slayton	MU, Huntington
Elizabeth Spangler	" "
Gary Allen Thompson	WVU, Morgantown
Richard K. Umstot, Jr.	" "
Richard M. Vaglienti	" "

Intern/Resident Members

Hasan Behdadnia	Wheeling
Michael W. Burkhart	Martinsburg
Richard A. Capito	Charleston
Max A. Harned	Wheeling
Douglas C. McCorkle	Morgantown
Frank L. Schwartz	"
Alfred Seco-Garcia	Wheeling

1983 Roster Corrections

The following physicians have notified headquarters staff of corrections in specialty listings as they appear in the 1983 Roster of Members of the West Virginia State Medical Association:

Society	*Name*	*Specialty Change*
Cabell	Frank Rivas	CD
Hancock	Timothy A. Brown	D
Harrison	Harry Bishop	R
	Teodoro Medina	I-GE
	Robert I. Mosenfelder	ObG
Jefferson	R. E. Rickel, Jr.	GP
Kanawha	Jerry Maliska	EM-GP
	Joseph T. Skaggs	Adm
Monongalia	Charlene F. Horan	I
	Frederick C. Whittier	I-NEP
Parkersburg Academy	Anantrai Vora	Pd
Tygart's Valley	Judith A. Wolfe	OTO-A

Review A Book

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication.

General Ophthalmology, 10th Edition, by Daniel Vaughan, M. D.; and Taylor Asbury, M. D. 407 pages. Price $17. Lange Medical Publications, Los Altos, California 94022. 1983.

Review of Medical Physiology, 11th Edition, by William F. Ganong, M. D. 643 pages. Price $20. Lange Medical Publications, Los Altos, California 94022. 1983.

Handbook of Pediatrics, 14th Edition, by Henry K. Silver, M. D.; C. Henry Kempe, M. D.; and Henry B. Bruyn, M. D. 883 pages. Price $13. Lange Medical Publications, Los Altos, California 94022. 1983.

Handbook of Poisoning, 11th Edition, by Robert H. Dreisbach, M. D. 632 pages. Price $11. Lange Medical Publications, Los Altos, California 94022. 1983.

The 1983 Program Committee

Chairman of the Program Committee for the 116th Annual Meeting of the West Virginia State Medical Association is Dr. David Z. Morgan of Morgantown. Other Committee members are Drs. Jean P. Cavender of Charleston, Michael J. Lewis of St. Marys, Kenneth Scher of Huntington, Roland J. Weisser of Morgantown, and Carl R. Adkins of Fayetteville.

No Registration Fee for Members

Members of the West Virginia State Medical Association will not be assessed a registration fee for the 116th Annual Meeting at the Greenbrier in White Sulphur Springs, August 25-27.

Interns, residents and medical students also will be registered without charge.

There will be a registration fee of $75 for out-of-state physicians attending the meeting.

Auxiliary Completes Program For 59th Annual Meeting

Mrs. John G. Bates of Cuthbert, Georgia, will be among honored guests when the Auxiliary to the West Virginia State Medical Association holds its 59th Annual Meeting at the Greenbrier in White Sulphur Springs August 25-27.

The meeting again will be held concurrently with the Annual Meeting of the State Medical Association. Mrs. Bates was installed in June as the new President of the American Medical Association Auxiliary. She will deliver the keynote address during the opening Auxiliary session beginning at 9:30 A. M. on Friday, August 26.

Also addressing the Auxiliary will be Mrs. William D. Hughes of Montgomery, Alabama, President of the Southern Medical Association Auxiliary.

More than 200 spouses of physicians are expected to attend the Auxiliary's business sessions, over which Mrs. Richard S. Kerr of Morgantown, the Auxiliary's President, will preside.

An invitation has been extended to all Auxiliary members to attend the first session of the State Medical Association's House of Delegates on Thursday, August 25, at 2:30 P. M. in Chesapeake Hall. Dr. Frank J. Jirka, Jr., AMA President, will be the principal speaker. Auxiliary members also are invited to attend formal opening ceremonies of the Association's 116th Annual Meeting at 9 A.M. on Friday, August 26, in the theater. Dr. Samuel P. Asper, President, Educational Commission for Foreign Medical Graduates, Philadelphia, will deliver the keynote Thomas L. Harris Address.

Mrs. Richard S. Kerr

Mrs. John G. Bates

Mrs. William D. Hughes

Dr. Harry Shannon of Parkersburg, President of the State Medical Association, will be recognized for brief remarks prior to Mrs. Bates' address Friday morning.

Mrs. Hughes will make her address during the second general session Saturday morning. During this session also, Mrs. Bates will install Mrs. T. Keith Edwards of Bluefield as President, and other new officers, and Mrs. Edwards will deliver her inaugural address.

For other scheduled business and sports activities, see the official Auxiliary program in this issue of *The Journal*.

Doctor Fix Heads Organization Of State Presidents

L. Walter Fix, M. D., of Martinsburg, President of the West Virginia State Medical Association in 1980-81, assumed the Presidency of the Organization of State Medical Association Presidents at an annual business meeting in Chicago in June.

OSMAP has a membership of current and past presidents, and presidents-elect, of state medical associations and societies. It is active in a number of endeavors, including presentation of forums on medical affairs and other programs held in conjunction with annual and interim meetings of the American Medical Association's House of Delegates.

Doctor Fix first served as a member of OSMAP's Steering Committee, and for the past year has been President-Elect.

Convention Exhibit To Feature Local Health Departments

Exhibits at the West Virginia State Medical Association's August 25-27 Annual Meeting at the Greenbrier will include one representing stepped-up efforts to provide more information for the medical community about local health department activities.

L. Clark Hansbarger, M. D., West Virginia's Director of Health, said he will provide a display of local health department activities and services, along with material identifying local health officers who serve throughout the state.

"I'm going to man that exhibit myself," Doctor Hansbarger said.

For the second year, the Annual Meeting program will include a 1 P. M. session on Thursday, August 25, in the Greenbrier's Jackson Room of state and local health officials to provide still more ongoing dialogue and discussion. Other physicians are invited to attend and participate in this meeting.

Sports Events Again Planned For Annual Meeting

Time will be at a premium, but physicians and auxiliary members plan to work annual golf and tennis competition into the tight business and scientific program schedule for the State Medical Association's Annual Meeting at the Greenbrier August 25-27.

Dr. William C Morgan of Charleston is the defending champion in the Medical Golf Tournament. The women's golf tournament was rained out in 1982.

Winners of last year's men's doubles tennis competition were Drs. Maurice A. Mufson of Huntington and Jose Oyco of Beckley. Results of the women's tennis competition were not available.

MU Graduate's Paper Wins

Dr. Douglas W. Given, a 1983 graduate of the Marshall University School of Medicine, presented the winning student research paper at the Southern Health Association annual meeting in June.

Doctor Given, a Strange Creek native, focused on farming accidents.

Students from Marshall, West Virginia University and the University of North Carolina presented papers at the Charleston meeting.

Medical Meetings

Aug. 1-3—International Society for Sexually Transmitted Disease Research, Seattle.

Aug. 1-5—Am. Venereal Disease, Seattle.

Aug. 22-24—Spinal Cord Regeneration & Recent Developments (Am. Paraplegia Society), Las Vegas.

Aug. 25-27—116th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

Aug. 26—W. Va. Chapter, Am. College of Emergency Physicians, White Sulphur Springs.

Sept. 7-10—Peripheral Vascular Disease Symposium (Saint Anthony Hospital), Columbus, OH.

Sept. 29-Oct. 1—Am. Assoc. for the Surgery of Trauma.

Sept. 29-Oct. 2—Am. Society of Internal Medicine, San Francisco.

Sept. 30-Oct. 1 — W. Va. Chapter, Am. College of Surgeons, Morgantown.

Oct. 2-5—Am. Neurological Assoc., New Orleans.

Oct. 5-8—Am. Thyroid Assoc., New Orleans.

Oct. 7-8—AMA Congress on Occupational Health, Beachwood, OH.

Oct. 16-21—Am. College of Surgeons, Atlanta.

Oct. 22-27—Am. Academy of Pediatrics, San Francisco.

Oct. 23-26—Am. College of Gastroenterology, Los Angeles.

Oct. 23-27—Am. College of Chest Physicians, Chicago.

Oct. 24-27—Am. College of Emergency Physicians, Atlanta.

Oct. 26-30—Am. Academy of Child Psychiatry, San Francisco.

Nov. 6-9—Scientific Assembly, Southern Medical Assoc., Baltimore.

Nov. 7-9—Am. Medical Women's Assoc., Dearborn, MI.

Nov. 18-22 — Gerontological Society of Am., San Francisco.

Nov. 30-Dec. 1—Am. College of Chemosurgery, Chicago.

1984

Jan. 19-21—Neurosurgical Society of the Virginias, Williamsburg, VA.

Jan. 27-29—17th Mid-Winter Clinical Conference, Charleston.

Feb. 12-15—W. Va. Perinatal Assoc., Snowshoe.

March 17—Annual Meeting, W. Va. Affiliate, American Diabetes Assoc., Wheeling.

CONVENTION PROGRAM

116th ANNUAL MEETING

of the

West Virginia State Medical Association

THE GREENBRIER, WHITE SULPHUR SPRINGS

August 25-27, 1983

THURSDAY MORNING
August 25
(Eastern Daylight Time)

9:00-5:00—Registration, Registration Lobby.

9:30—Pre-Convention Meeting of the Council. John B. Markey, M.D., *Presiding* (Fillmore Room, with Luncheon in Tyler Room).

THURSDAY AFTERNOON

1:00—Public Health-Local Health Officer Conference (Jackson Room).

2:30—First Session of the House of Delegates. Harry Shannon, M.D., *Presiding* (Chesapeake Hall).

Invocation—Joe N. Jarrett, M.D.

Address: Frank J. Jirka, Jr., M.D., President, American Medical Association.

Recognition of AMA-ERF Grants to the West Virginia University and Marshall University Schools of Medicine.

Business Meeting.

5:00—Committee on Resolutions. John J. Mahood, M.D., *Presiding* (Directors' Room).

FRIDAY MORNING
August 26

8:30-5:00—Registration, Registration Lobby.

Breakfast Meetings

7:30—Section on Internal Medicine. Maurice A. Mufson, M.D., *Presiding* (Tyler Room).

Guest Speaker: George J. Pazin, M.D. Subject: "Genital Herpes—Signs, Sexual Relationships and Source Contacts of Women with First-Time Disease."

7:30—Section on Dermatology. William A. Welton, M.D., *Presiding* (Directors' Room).
Case Presentations.

7:30—Section on Surgery. Robert J. Reed III, M.D., *Presiding* (Pierce Room).

Guest Speaker: Alvin L. Watne, M.D., Professor and Chairman of Surgery, West Virginia University School of Medicine, Morgantown. Subject: "Emergent Surgery for Acute Colicystitis."

Opening Exercises
(Theater)

9:00—Call to Order—Harry Shannon, M.D., President, West Virginia State Medical Association.

Invocation—Joseph T. Skaggs, M.D.

Address of Welcome — Harry Shannon, M.D.

Introduction of David Z. Morgan, M.D., 1983 Program Committee Chairman, and other Members of his Committee.

"The Thomas L. Harris Address."

Samuel P. Asper, M.D., President, Educational Commission for Foreign Medical Graduates, Philadelphia, and Professor of Medicine, The Johns Hopkins University, Baltimore. Subject: "Strengths and Weaknesses of the U. S. Role in International Medicine."

First General Session
9:45-12:30

"Symposium on Sexually Transmitted Diseases"

David Z. Morgan, M.D., *Moderator*

9:45—Edmund C. Tramont, M.D., COL, MC, USA, Chief, Infectious Diseases, Department of Bacterial Diseases, Walter Reed Army Institute of Research, Washington, DC. Subject: "Syphilitic and Gonococcal Infections."

10:15—Lee P. Van Voris, M.D., Infectious Diseases and Coordinator of Medical Education, Department of Medicine, Hamot Medical Center, Erie, Pennsylvania (formerly Associate Professor of Medicine, Marshall University School of Medicine, Huntington). Subject: "Non - Luetic, Non-Gonococcal Venereal Diseases."

10:45—Coffee Break to Visit Exhibits.

11:00—George J. Pazin, M.D., Associate Professor of Medicine, University of Pittsburgh School of Medicine, Pittsburgh. Subject: "Transmissible Diseases of the Gay Patient."

11:30—Jack L. Summers, M.D., Chairman, Department of Urology, Akron City Hospital, Akron, Ohio, and Professor of Urology, Northeastern Ohio Universities College of Medicine, Akron.
Subject: "Sexual Mores in the 1980s."

12:00—Questions, Answers and Discussion.

12:30—Recess for Lunch.

FRIDAY AFTERNOON

12:30—Luncheon Honoring Past Presidents of the West Virginia State Medical Association. John B. Markey, M.D., *Presiding* (Tyler Room).

12:30—Cancer Committee. Business Meeting. Alvin L. Watne, M.D., *Presiding* (Jackson Room).

12:30—West Virginia Medical Institute, Inc., Board of Trustees Meeting. Harry S. Weeks, Jr., M.D., *Presiding* (Virginia Room).

1:00—West Virginia Chapter, American College of Emergency Physicians. Roger Frome, M.D., *Presiding* (Pierce Room).

Guest Speakers: Warren T. Anderson, M.D. Subject: "Update on Emergency Cardiology."

William E. Walker, M.D., Huntington. Subject: "Update on Toxicology."

1:00—West Virginia State Neurosurgical Society. Carrel M. Caudill, M.D., *Presiding* (Buchanan Room).

Business meeting.

2:00—West Virginia Chapter, American Academy of Pediatrics. Kenneth L. Wible, M.D., *Presiding* (Fillmore Room).

Guest Speakers: Karen A. Connors, Ph.D., Adjunct Assistant Professor of Pediatrics and Infant Stimulation Specialist, West Virginia University Affiliated Center for Developmental Disabilities, Morgantown; and Jan K. Nash, M.S.W., Developmental Disabilities Coordinator, Valley Community Mental Health Center, Morgantown. Subject: "Enhancing the Coping Strategies and Parenting Skills of Families with Developmentally Delayed Infants."

2:00—Section on Orthopedic Surgery. Darrell C. Belcher, M.D., *Presiding* (West Virginia Room).

Guest Speaker: Robert H. Cofield, M.D., Associate Professor, Mayo Medical School; Consultant, Orthopedic Surgery, Mayo Clinic, Rochester, Minnesota. Subject: "Management of Rotator Cuff Disease."

2:00—West Virginia District Branch, American Psychiatric Association. Ralph S. Smith, Jr., M.D., *Presiding* (Lee Room).

Guest Speakers: Armando R. Favazzo, M.D,. Professor of Psychiatry, University of Missouri Medical Center, Columbia. Subject: "Cultural Context of Self-Mutilation."

5:00—Committee on Nominations. Stephen D. Ward, M.D., *Presiding* (Washington Room).

FRIDAY EVENING

6:00—Cocktail Party. The University of Virginia Medical School Foundation. William C Morgan, M.D., *host* (Old White Club).

6:00—Cocktail Party. West Virginia Chapter, Medical College of Virginia Alumni Association. A. Thomas McCoy, M.D., *in charge* (Old White Club).

6:30—Les Batards Reception. L. Walter Fix, M.D., *in charge* (Virginia Room).

6:30—Cocktail Party. West Virginia University Alumni Association. Richard A. DeVaul, M.D., *in charge* (Spring Room).

SATURDAY MORNING
August 27

9:00-2:00—Registration, Registration Lobby.

Breakfast Meetings

8:00—Section on Urology. John A. Belis, M.D., *Presiding* (Jackson Room).

Guest Speaker: Jack L. Summers, M.D. Subject: "Iridium 192 Therapy for Carcinoma of the Prostate."

8:00—West Virginia Gastrointestinal Society. Duane D. Webb, M.D., *Presiding* (Directors' Room).

Guest Speaker: Doctor Webb. Subject: "Hepatitis Vaccine and Antigens."

8:00—West Virginia Radiological Society. Johnsey L. Leef, Jr., M.D. *Presiding* (Lee Room).

Guest Speaker: Peter Armstrong, M.D., Professor and Vice Chairman, Department of Radiology, University of Virginia, Charlottesville. Subject: "Radiology of Diffuse Lung Disease."

Second General Session
(Theater)
9:30-12:15

"Symposium on Cardiovascular Diseases"

Moderator: Jean P. Cavender, M.D.

9:30—John C. Alexander, Jr., M.D., Chief, Section of Cardiothoracic Surgery, West Virginia University School of Medicine, Morgantown. Subject: "Cardiovascular Surgery—An Update."

10:15—Stafford G. Warren, M.D., Clinical Professor of Medicine, WVU Charleston Division. Subject: "New Developments in the Management of Cardiac Arrhythmias."

11:00—Coffee Break to Visit Exhibits.

11:15—Warren T. Anderson, M.D., Clinical Associate Professor of Cardiology, West Virginia University School of Medicine, Morgantown. Subject: "The Management of Congestive Heart Failure."

12:00—Questions, Answers and Discussion.

12:15—Recess for Lunch.

SATURDAY AFTERNOON

12:00—Publication Committee. Stephen D. Ward, M.D., *Presiding* (Jackson Room).

12:00—West Virginia State Society of Anesthesiologists. Jeanne A. Rodman, M.D., *Presiding* (Directors' Room).

Guest Speaker: John C. Alexander, Jr., M.D. Subject: "Problems in Anesthesia Unique to Cardiovascular Surgery."

3:00—Second and Final Session of the House of Delegates. Harry Shannon, M.D., *Presiding* (Chesapeake Hall).

Invocation—Robert D. Hess, M.D.

Presidential Address: Harry Shannon, M.D.

Presentation of New Officers of Auxiliary to the West Virginia State Medical Association.

Presentation of Honor Guests.

Business Meeting.

Election of Officers.

Installation of Carl R. Adkins, M.D., Fayetteville, as President of the West Virginia State Medical Association.

SATURDAY EVENING

7:00—Reception for West Virginia State Medical Association Members and Guests (Chesapeake Terrace).

8:00—Dinner Honoring Officers of the West Virginia State Medical Association and Auxiliary (Chesapeake Hall).

A WORD OF THANKS

The 1983 Program Committee, and the officers and members of the West Virginia State Medical Association, wish to acknowledge with sincere thanks grants received from the following firms to help support the Scientific Program for this year's 116th Annual Meeting.

CIBA PHARMACEUTICAL COMPANY
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(The firms listed above are those which had allocated funds to the Scientific Program as this issue of the *The Journal* went to press. Additional contributors will be listed in the Official Program to be distributed at the Greenbrier.)

DELEGATES AND ALTERNATES

BOONE (2) — Delegates, Robert B. Atkins and Manuel T. Uy, Madison. Alternates, Sriramloo Kesari and Probhond Chinuntdet, Madison.

BROOKE (2) — Delegates, Rogelio L. Velarde, Follansbee; and Richard Bombach, Wheeling. Alternates, Leticia Peralta-Velarde, Follansbee; and W. T. Booher, Jr., Wellsburg.

CABELL (14)—Delegates, Stephen K. Wolfe, Jack Leckie, Charles E. Turner, Robert R. Dennison, Jr., William L. Neal, Tara Sharma, John D. Harrah, Earl J. Foster, John Gearhart, M. Bruce Martin, Joseph B. Touma, Robert W. Lowe, Winfield C. John and S. Bruce Chandor, Huntington. Alternates, Hossein Sakhai, Jose I. Ricard, Robert L. Bradley, Thomas F. Scott, Roy A. Edwards, Jr., N. G. Baranetsky and Gary G. Gilbert, Huntington; W. W. Mills and H. S. Mullens, Kenova; K. V. Raman, John A. Hunt, W. F. Daniels, Jr., Kenneth Scher and Seyed H. Hadi-Sadegh, Huntington.

CENTRAL WEST VIRGINIA (3) — Delegates, Joseph B. Reed, Buckhannon; Alfred J. Magee, Summersville; and Greenbrier Almond, Buckhannon. Alternates, John A. Mathias, Buckhannon; and Frank A. Scattaregia, Weston.

EASTERN PANHANDLE (4)—Delegates, Francisco D. Sabado, Jr., John S. Palkot, L. Walter Fix and George C. Soteropoulos, Martinsburg. Alternates, C. Vincent Townsend, Robert S. Strauch, R. J. Estogoy and Edward P. Quarantillo, Jr., Martinsburg.

FAYETTE (3) — Delegates, Joe N. Jarrett and Serafino S. Maducdoc, Jr., Oak Hill; and Rolando C. Ramirez, Montgomery. Alternates, Honorato M. Aguila and Chuan H. Lee, Oak Hill; and Adin L. Timbayan, Montgomery.

GREENBRIER VALLEY (4)—Delegates, Stephen L. Sebert, Fairlea; Romeo R. Ednacot, Ronceverte; Harvey A. Martin, White Sulphur Springs; and Charles E. Weinstein, Ronceverte. Alternates, Robert K. Modlin, Benjamin L. Plybon, Lynn N. Smith and Robert L. Wheeler, Ronceverte.

HANCOCK (4)—Delegates, Pedro R. Montero, Jr., Chester; Timothy A. Brown, Antonio S. Licata and Thomas J. Beynon, Weirton.

HARRISON (7) — Delegates, James E. Bland, James Genin, Joseph D. Wright, John A. Bellotte, Erlinda L. de la Pena, Clarksburg; Sidney B. Jackson, Bridgeport; and Robert D. Hess, Clarksburg. Alternates, Louis C. Palmer, Bridgeport; Chinmay K. Datta, Cordell A. de la Pena, George W. Shehl, T. H. Chang and David A. Lynch, Clarksburg.

JEFFERSON (2)—Delegate, L. Mildred Williams, Charles Town. Alternate, S. K. G. Menon, Ranson.

KANAWHA (21)—Delegates, Alberto G. Capinpin, Charleston; W. Alva Deardorff, South Charleston; Donald E. Farmer, Robert L. Ghiz, Carl B. Hall, Echols A. Hansbarger, Jr., Sherman E. Hatfield, Charleston; George W. Hogshead, Nitro; James W. Lane, K. G. MacDonald, Sr., Tony Majestro, Jimmy L. Mangus, John B. Markey, Lionel Nair, Robert B. Point, Warren Point, Charleston; Richard C. Rashid, South Charleston; William C. Revercomb, Jr., Charleston; Carl J. Roncaglione, South Charleston; and George A. Shawkey and Joseph T. Skaggs, Charleston. Alternates, Adla Adi, Clinton A. Briley, Jr., William H. Carter, Robert James Clubb, George V. Hamrick, Fred F. Holt, Thomas J. Janicki, Alberto C. Lee, Rogelio T. Lim, Eric P. Mantz, William O. McMillan, Jr., William C Morgan, Jr., Pejawar M. Rao, William G. Sale, Richard H. Sibley, Charleston; Joseph A. Smith, Dunbar; and George E. Tomas, Alfredo C. Velasquez, Charles C. Weise, Ronald L. Wilkinson and John F. Zeedick, Charleston.

LOGAN (4)—Delegates, Chanchai Tivitmahaisoon, Logan; Thomas P. Long, Man; Herbert D. Stern, Logan; and Enrico V. Rallos, Gilbert. Alternates, Subhash Bhanot, West Logan; Carlos F. DeLara, Logan; Noor Laynab, Whitman; and Alberto M. Garma, Logan.

MARION (4)—Delegates, Babu R. Devabhakthuni, Jack S. Koay, Guy David Leveaux, Mack I. McClain and Stanard L. Swihart, Fairmont. Alternates, Michael A. Grant, Chi Meen Lee, David M. McLellan, William L. Mossburg and P. Kent Thrush, Fairmont.

MARSHALL (3)—Delegates, Carlos C. Jimenez, Kenneth J. Allen and Carl L. Anderson, Glen Dale. Alternate, Jose J. Ventosa, Jr., Glen Dale.

MASON (2) — Delegates, Richard L. Slack and Aarom Boonsue, Point Pleasant. Alternate, Mel P. Simon, Point Pleasant.

McDOWELL (3)—Delegates, John S. Cook, Richard O. Gale and Louis A. Vega, Welch. Alternates, Bernard M. Swope, Vernon J. Magnus and Arthur Allen Carr, Welch.

MERCER (7)—Delegates, David F. Bell, Jr., and J. E. Blaydes, Jr., Bluefield; Mario Cardenas and Frank J. Holroyd, Princeton; John J. Mahood, Bluefield; William Prudich, Montcalm; and Edward M. Spencer, Bluefield.

MINGO (3)—Delegates, Edward B. Headley, Delbarton; Nikhanth Purohit and Diane E. Shafer, Williamson. Alternate, C. H. Yajnik, Williamson.

MONONGALIA (15)—Delegates, Donald C. Carter, Ralph W. Ryan, George A. Curry, Eric T. Jones, J. David Blaha, A. Hugh Lindsay, David Z. Morgan, Robert L. Smith, Herbert E. Warden, Roland J. Weisser, Jr., Orlando F. Gabriele, William A. Neal,

Martha D. Mullett, Richard S. Kerr and J. W. Kessel, Morgantown. Alternates, James G. Arbogast, Robert Bettinger, K. Douglas Bowers, Jr., Thomas S. Clark, Thomas W. Crosby, Anthony G. Di Bartolomeo, John L. Fullmer, R. Brooks Gainer II, Frank C. Griswold, Paul J. Jakubec, Michael T. Hogan, Roger E. King, Lawrance S. Miller and Alvin L. Watne, Morgantown.

OHIO (10)—Delegates, George E. Bontos, Robert S. Robbins, James C. Durig, D. L. Latos, Milton E. Nugent, Robert J. Reed III, M. D. Reiter, Stephen D. Ward, Harry S. Weeks, Jr., and D. Verne McConnell, Wheeling.

PARKERSBURG ACADEMY (8) — Delegates, Michael J. Lewis, St. Marys; Billie M. Atkinson, Parkersburg; Logan W. Hovis, Vienna; and Paul W. Burke, William E. Gilmore, John E. Beane and Robert F. Gustke, Parkersburg.

POTOMAC VALLEY (3)—Delegates, Jeffrey S. Life, Romney; and Paul T. Healy and James C. Bosley, Keyser. Alternates, Suratkal V. Shenoy and Robert W. McCoy, Jr., Keyser.

PRESTON (2)—Delegates, Patricia Haase, Masontown; and Thomas A. Haymond, Reedsville. Alternates, John W. Trenton, Kingwood; and William H. Harriman, Jr., Terra Alta.

RALEIGH (8) — Delegates, Norman W. Taylor, Jose L. Oyco, Michael T. Webb, Nancy R. Webb, Worthy W. McKinney, William D. McLean, William C. Covey, Jr., and A. Allen Bliss, Beckley. Alternates, S. L. Francis, Lamberto C. Maramba, Isidro G. Zarsadias, Jr., Iligino Salon, Mario C. Ramas, Prospero B. Gogo, Richard D. Richmond, and T. Rosal Rojas, Jr., Beckley.

SUMMERS (2)—Delegate, Eduardo L. Jimenez, Hinton. Alternate, Chandra P. Sharma, Hinton.

TYGART'S VALLEY (6) — Delegates, Karl J. Myers, Jr., Philippi; Gene W. Harlow, Grafton; Michael M. Stump V, Elkins; Halberto G. Cruz, Philippi; and Jerome C. Arnett, Jr., and Hugh H. Cook, Jr., Elkins. Alternates, Robert R. Rector and James B. Magee, Elkins; Samuel M. Santibanez, Grafton; Mary E. Myers, Philippi; and Melanio D. Acosta, Jr., Parsons.

WESTERN (3)—Delegates, Herminio L. Gamponia, Spencer; James T. Hughes and Ali H. Morad, Ripley.

WETZEL (2)—Delegates, Donald A. Blum and K. M. Chengappa, New Martinsville.

WYOMING (2)—Delegates, Frank J. Zsoldos and Ross E. Newman, Mullens.

Reception Committee

Frank J. Holroyd
Harry S. Weeks, Jr.
Harry Shannon
David Z. Morgan
Carl R. Adkins
George A. Shawkey
Stephen D. Ward
Robert R. Weiler

Joseph A. Smith
Carl J. Roncaglione
Jack Leckie
Thomas F. Scott
Robert D. Hess
Roger E. King
Worthy W. McKinney
Sherman E. Hatfield

John B. Markey
Arthur A. Abplanalp
John J. Mahood
William E. Gilmore
L. Walter Fix
John A. Mathias
Norman W. Taylor
Joseph J. Renn III

Charles C. Weise
Joseph T. Skaggs
D. L. Latos
George W. Hogshead
Jean P. Cavender
George A. Curry
John A. Bellotte
Richard S. Kerr

David B. Gray
Robert R. Rector
Diane E. Shafer
Catalino B. Mendoza, Jr.
Herbert D. Stern
L. Mildred Williams
Warren Point
Charles E. Turner
Cordell A. de la Pena

Official Program

AUXILIARY

to the

West Virginia State Medical Association

59th Annual Meeting

THE GREENBRIER
White Sulphur Springs

August 25-27, 1983

THURSDAY AFTERNOON

August 25

2:00-5:00—Registration, Lower Lobby.

2:30—First Session of the House of Delegates, West Virginia State Medical Association (Chesapeake Hall).

Address by Frank J. Jirka, Jr., M. D., President, American Medical Association.

Recognition of AMA-ERF Grants to the West Virginia University and Marshall University Schools of Medicine.

4:00—Pre-Convention Board Meeting, Mrs. Richard S. Kerr, President, presiding (Fillmore-Van Buren Rooms).

FRIDAY MORNING

August 26

9:00-4:00—Registration, Lower Lobby.

8:00—Past Presidents' Breakfast, Mrs. Logan W. Hovis, Immediate Past President, presiding (Virginia Room).

9:30—Formal Opening of the Convention, Mrs. Richard S. Kerr, President, presiding (Fillmore-Van Buren Rooms).

Invocation, Pledge of Loyalty and Pledge to Flag.

In Memoriam—Mrs. G. A. Shawkey.

Introduction of Honored Guests.

Presentation of Harry Shannon, M. D., President, West Virginia State Medical Association.

Introduction of Convention Chairman — Mrs. Logan W. Hovis.

Roll Call of Delegates — Mrs. Charles C. Weise, Recording Secretary.

Declaration of a Quorum—Mrs. J. L. Mangus, Parliamentarian.

Keynote Address — Mrs. John G. Bates, President, American Medical Association Auxiliary.

Credentials and Registration—Mrs. Wilson P. Smith.

Convention Rules of Order — Mrs. J. L. Mangus, Parliamentarian.

Report of the 1982 Convention Reading Committee.
Treasurer's Report—Mrs. Harvey Reisenweber.

Recommendations from Pre-Convention Board Meeting.

New Business.

Report of the 1983 Nominating Committee, First Reading—Mrs. Logan W. Hovis.

Election of the 1984 Nominating Committee.

Reports of Officers and Chairmen of Standing Committees. (Those published in the Annual Reports Book will not be read.)

Presentation of Regional Directors (and two-minute reports by county presidents):

Northern Region—Mrs. A. S. Licata.

Eastern Region — Mrs. Thomas W. Crosby.

Western Region—Mrs. Mario Cardenas.

Southern Region — Mrs. William M. Jennings.

Central Region—Mrs. Jose M. Serrato.

Announcements.

Door Prizes—Mrs. Frank J. Holroyd.

Recess.

FRIDAY AFTERNOON

Bridge (Trellis Lobby). Host Auxiliary, Eastern Panhandle, Mrs. Harvey D. Reisenweber.

Golf. Host Auxiliary, Kanawha County, Mrs. John B. Markey.

Tennis. Host Auxiliary, Raleigh County, Mrs. Prospero B. Gogo.

(Times to be announced).

SATURDAY MORNING

August 27

9:00-10:00—Registration, Lower Lobby.

9:00—Second General Session, Mrs. Richard S. Kerr, President, presiding (Fillmore-Van Buren Rooms).

Introduction of Honored Guests.

Roll Call of Delegates — Mrs. Charles C. Weise.

Declaration of a Quorum—Mrs. J. L. Mangus, Parliamentarian.

Address—Mrs. William D. Hughes, President, Southern Medical Association Auxiliary.

Convention Announcements — Mrs. Logan W. Hovis.

Credentials and Registration—Mrs. Wilson P. Smith.

Presentation of AMA-ERF Awards—Mrs. Herman Fischer, Chairman. Recognition of AMA-ERF Grants to the West Virginia University and Marshall University Schools of Medicine.

Unfinished Business.

Report of the 1983 Nominating Committee, Second Reading—Mrs. Logan W. Hovis.

Election of Officers.

Installation of Officers — Mrs. John G. Bates, President, American Medical Association Auxiliary.

Presentation of President's Pin and Gavel, Mrs. Richard S. Kerr.

Presentation of Past President's Pin, Mrs. Logan W. Hovis.

Inaugural Address—Mrs. T. Keith Edwards.

Announcements.

Door Prizes.

Adjournment.

11:00—Post-Convention Board Meeting — Mrs. T. Keith Edwards, President, presiding (Fillmore-Van Burean Rooms).

SATURDAY AFTERNOON

3:00—Second and Final Session of the House of Delegates, West Virginia State Medical Association (Chesapeake Hall).

Presidential Address: Harry Shannon, M. D.

Installation of Carl R. Adkins, M. D., Fayetteville, as 1983-84 President of the West Virginia State Medical Association.

(Auxiliary members are invited and urged to attend).

SATURDAY EVENING

7:00—Reception for State Medical Association members and guests (Chesapeake Terrace).

8:00—Dinner honoring officers of the West Virginia State Medical Association and the Auxiliary (Chesapeake Hall).

SCIENTIFIC EXHIBITS

AMERICAN DIABETES ASSOCIATION, WEST VIRGINIA AFFILIATE, INC.

"DIABETES." Information on the work and goals of the group.

Mike Murray, Affiliate member, and Douglas L. Jones, M. D., member, Board of Directors.

BUREAU OF VENEREAL DISEASE CONTROL, WEST VIRGINIA STATE HEALTH DEPARTMENT

"SEXUALLY TRANSMITTED DISEASES." The two-panel display features one of the prominent sexually transmitted diseases. Current STD management materials are available for pick-up by medical professionals. In addition, representatives from the West Virginia Venereal Disease Program will be manning the exhibit to discuss the state program and address other inquiries concerning the STDs.

Ronald Bryant, Director, Venereal Disease Program, and Gregory Moore and Alan Bernstein, Venereal Disease Field Representatives.

CHARLESTON AREA MEDICAL CENTER AND AUXILIARY TO CAMC MEMORIAL DIVISION

"CAMC EXHIBIT." The exhibit will contain CAMC educational and informational materials, including copies of a physician's referral brochure, photographs of CAMC, and a slide/tape show on the medical center.

Joseph T. Skaggs, M. D., Director of Medical Affairs; and William B. Ferrell, Assistant to Executive Vice President.

"TEL-MED" (AUXILIARY). Tel-Med, a free health information program, is a library of taped telephone messages on a variety of health and health-related subjects that have been approved and endorsed by the CAMC medical staff and Kanawha Medical Society. To use Tel-Med, dial the local number, 343-4400 (Charleston area) or the toll-free number outside of Charleston, 1-800-352-6510, and request the tape of your choice. Operating hours are from 9 A. M. to 8 P. M. six days a week, and from 1 to 4 P. M. on Sundays and holidays.

Frances McMillan, Health Education Chairman.

DEPARTMENT OF MEDICINE, MARSHALL UNIVERSITY SCHOOL OF MEDICINE

"IMPACT OF VIRAL RESPIRATORY DISEASES ON INFANTS AND YOUNG CHILDREN IN A RURAL AND SUBURBAN AREA OF SOUTHERN WEST VIRGINIA." Acute viral respiratory disease occurring in children in Huntington, West Virginia (urban children), or in the hollows surrounding Huntington (rural children) was evaluated from September, 1978, through March, 1980. Epidemics of illnesses occurred simultaneously in the urban and rural groups. Among both the urban and rural ambulatory children, adenoviruses were the most common viruses isolated, and respiratory syncytial virus was the second most common viral pathogen isolated. Among the urban and rural hospitalized children, respiratory syncytial virus was the most common virus isolated. The risk of hospitalization because of respiratory disease was found to be one in every 20 children during the first four years of life, and the estimated risk of hospitalization because of respiratory syncytial virus infection was one in 30.

Maurice A. Mufson, M. D., Chairman.

DISABILITY DETERMINATION SERVICE, WEST VIRGINIA DIVISION OF VOCATIONAL REHABILITATION

"EVALUATION OF DISABILITY FOR SOCIAL SECURITY: HEMATOLOGY/ONCOLOGY, PEDIATRICS AND ORTHOPEDICS." Three board certified physicians will present video tapes on difficult aspects of reporting for independent medical assessment: Hematology/Oncology, A. Rafael Gomez, M. D., Charleston; Pediatrics, Marcel G. Lambrechts, M. D., Charleston, and Orthopedics, Robert W. Lowe, M. D., Huntington.

These presentations also should aid attending physicians in preparing their abstracts for Social Security.

David H. Cleland, Medical Relations Officer.

FAMILY MEDICINE FOUNDATION OF WEST VIRGINIA (WEST VIRGINIA CHAPTER, AMERICAN ACADEMY OF FAMILY PHYSICIANS)

"FUND RAISER—SEIGLE PARKS, M. D." The Foundation will have on display three paintings by Seigle Parks, M. D., one of our family physicians. Doctor Parks donated these paintings for a fund raiser to benefit the Foundation. Please stop by our exhibit where these paintings will be on display. We also will have information on the long-term and short-term goals of the Foundation.

Robert D. Hess, M. D., President; Thomas P. Long, M. D., Trustee, and Chris Ferrell.

NATIONWIDE INSURANCE—MEDICARE

"MEDICARE OPERATIONS." Nationwide invites you to stop by and discuss your Medicare problems. Find out about CPT-4 coding and our electronic media claims billing available to your offices. Learn how you can receive payments faster.

James A. Cuppy, Electronic Media Claims Manager; James B. Irwin, Field Service Manager, and Betty Rickenbacker, West Virginia Field Manager.

SOUTHERN MEDICAL ASSOCIATION

"SOUTHERN MEDICAL ASSOCIATION." Southern Medical will have information available on the

advantages of membership such as continuing medical education-Dial Access, regional postgraduate conferences, leadership seminars, medical malpractice seminars, the annual scientific assembly, and the *Southern Medical Journal*. Also available will be material on financial benefits to members such as the IRA, Keogh Plan, retirement and insurance programs, research project fund, and loans and scholarships.

Robert P. Mosca, Director, Member Services, and Marc B. Wilson, Sales Coordinator.

STATE MEDICAL ASSOCIATION'S GROUP INSURANCE AND PROFESSIONAL LIABILITY PLANS

McDonough Caperton Shepherd Group, managing general agent of the State Medical Association's group insurance and professional liability plans, will have on hand information describing each of the programs officially endorsed by the Association. Representatives also will be available to answer questions about the plans available.

Mike Costello and Tom Auman, representatives.

JOHN TAYLOR, M. D.

"MANAGEMENT OF RECURRENT BASAL CELL EPITHELIOMA." Some aspects of the etiology, morphology and photobiology of basal cell carcinomas are treated. A discussion concerning the different treatment modalities available is given and the advantages and disadvantages of each pointed out. Metastasizing basal cell carcinoma is discussed. Three cases of multiply recurrent basal cell carcinoma causing extensive debility and multiple ablative attempts are demonstrated. A recommendation for definitive surgical excision utilizing either frozen section control or the Mohs technique is made, particularly in the recurrent lesions or those of a morpheaform or ulcerative invasive growth pattern.

John Taylor, M. D., Bluefield, West Virginia.

U. S. ARMY MEDICAL DEPARTMENT

"U. S. ARMY MEDICAL DEPARTMENT." Career opportunities as a member of the Army Medical Department, U. S. Army Reserve.

Major James E. Kuza and Major Sheila Bowman, USAR AMEDD Procurement Counselors, and Captain David Royer, USA AMEDD Procurement Counselor.

U. S. NAVY RECRUITING DISTRICT, LOUISVILLE, KENTUCKY

"COMPUTER-ASSISTED MEDICAL DIAGNOSIS OF ABDOMINAL PAIN." We will present a videotape demonstration of our system for computer-assisted medical diagnosis of abdominal pain. The system currently is undergoing sea trials aboard approximately 100 submarines.

HMC William Brandshagen, USN, and HM1 Ken Devore, USN.

WEST VIRGINIA DEPARTMENT OF HEALTH

"YOUR LOCAL HEALTH DEPARTMENT." This is a display of local health department activities and services as well as a highlight of local health officers in each county.

L. Clark Hansbarger, M. D., Director.

WEST VIRGINIA DIVISION OF VOCATIONAL REHABILITATION AND WEST VIRGINIA WORKERS' COMPENSATION FUND

"JOINT VOCATIONAL REHABILITATION-WORKERS' COMPENSATION PROGRAM." The exhibit features a three-screen audiovisual presentation that describes the program for persons injured on the job, a program operated jointly by the West Virginia Division of Vocational Rehabilitation and the West Virginia Workers' Compensation Fund. Side panels of the exhibit treat in detail the services provided by the two agencies.

Samuel B. Mann, Lewisburg District Supervisor, DVR; and Thomas Lyttleton, Rehabilitation Counselor, Lewisburg Office, DVR (Workers' Compensation representatives to be named).

WEST VIRGINIA MEDICAL INSTITUTE, INC.

"WEST VIRGINIA MEDICAL INSTITUTE, INC. —DRG DISPLAY." The exhibit will display information on classification by Diagnosis Related Groups (DRGs). An on-line CRT terminal will be available for accessing selected DRG data from WVMI's data base for Medicare and Medicaid patients. In addition, samples of hard-copy DRG reports by hospital and physician will be available. WVMI staff and physician committee members will attend the display.

WEST VIRGINIA PERINATAL ASSOCIATION

"WEST VIRGINIA PERINATAL ASSOCIATION." This exhibit will announce the formation of a new organization which will improve health care to pregnant women and newborns. The organization is multidisciplinary, including obstetricians, pediatricians and family practitioners.

Martha D. Mullett, M. D., President.

WEST VIRGINIA PHYSICAL THERAPY ASSOCIATION

"PEDIATRIC REHABILITATION: CURRENT CONCEPTS OF CARE." The display is designed to depict current concepts in pediatric rehabilitation. Emphasis is on informing physicians of the changing roles and responsibilities of the physical therapy practitioner.

Dee-dee Daniel and Hugh Murray, physical therapists.

WEST VIRGINIA POISON CENTER

"GET TO KNOW ABOUT POISONS." Describes the various functions of, and materials available to, the professional and lay public through the West Virginia Poison System.

Terri DeFazio, Susie Aston, Sheila Totten, Donna Samples, and Cynthia Tennant, poison specialists.

WEST VIRGINIA UNIVERSITY HOSPITAL

"WEST VIRGINIA UNIVERSITY HOSPITAL TODAY!" The exhibit illustrates some of the technologies available to referring physicians and their patients. Vascular specialists screen patients with noninvasive procedures for hemodynamically significant carotid artery stenosis. Angioplasty to open narrowed or occluded blood vessels is the cardiologist's newest tool. Surgical specialists use lasers for cutting and vaporization of tissue. Neonatal life support continues to increase in sophistication. I-125 implantations are used to treat cancer of the prostate and pancreas. Radiologists enjoy more refined images of the malfunctioning kidney with percutaneous procedures. Spend a few minutes to see "West Virginia University Hospital Today!"

David Fine, Administrator; Andrew Lasser, Associate Administrator, and Virginia Nugent, Administrative Assistant.

WEST VIRGINIA UNIVERSITY SCHOOL OF MEDICINE

"WEST VIRGINIA UNIVERSITY SCHOOL OF MEDICINE REACHES OUT." Because the WVU School of Medicine exists "for the sake of West Virginians," every department is involved in activities which purposely extend beyond the campus boundaries. This exhibit portrays many examples of programs designed to reach out and make a direct, practical difference for individuals and communities across West Virginia. Examples range from educating MDs who will establish their practice in West Virginia communities, to hearing clinics for the elderly, to genetics screening programs for prospective parents, and to providing orthopedic consultation at a home for handicapped children.

Robert L. Smith, M. D., Assistant Dean, School of Medicine; Linda C. Morningstar, Consultant, School of Medicine, and Robert E. Kristofco, Manager, CME, School of Medicine.

ANNUAL REPORTS

Committee on Insurance

The year 1983 marks the 35th of the West Virginia State Medical Association's Insurance Program. Since its establishment in 1948, hundreds of doctors throughout West Virginia have been the recipients of benefits under this program.

Throughout the years, each plan has been continuously upgraded and new plans added to meet the needs of our members. Two examples would be the following:

Major Medical Plan — As reported last year, the Committee approved our insurance administrator's recommendation to change insurance companies and expand benefits under this plan. As a result, the number of participants has increased from 206 to 328.

Life Plan — Within the past year, participation in this plan has increased by 25 per cent.

In addition to the above, our members continue to avail themselves of the following plans which comprise our total insurance portfolio:

Income Protection (Disability)
Accidental Death & Dismemberment
Hospital Indemnity Plan
Office Overhead Expense
Coordinated Pension Services
Professional Liability Insurance (separate report attached)

Summarization

Our total insurance program available to members and their employees continues to provide a very viable benefit for members of the West Virginia State Medical Association. Since 1948, it has stood the test of time with the continuous support of our members and the professional competence of our administrator.

Professional Liability

The Professional Liability Insurance Program is a combination of effort on the part of the Medical Association, CNA Insurance Company and McDonough Caperton Shepherd Association Group to provide a first-rate professional liability program for eligible Association members.

Common representation of all physicians in the program by the Managing General Agent — the role occupied by McDonough Caperton Shepherd — is important for program responsiveness. Provision exists for West Virginia physicians to be important contributors in claim review and peer review. Physicians are given an opportunity to be heard concerning any element of the program.

Several accomplishments for the program need to be reported:

1. A new computer program that rates and prints the policies in Charleston is functional.
2. A new computer claim program that provides statistical data for loss control efforts now exists.
3. The District Claim Review Panels are functional.
4. The Professional Evaluation Committee has provided input in several areas of concern.
5. Several loss control programs have been presented to medical groups.

The Association-endorsed program is currently in sound condition. This will continue as long as physicians work to support the program. This includes providing medical input into the process of selecting insured physicians. The Association wants the selection process to be fair, but feels strongly that physicians with repeated poor loss experience or evidence of improper practices should not be insured in the program. The program must remain financially healthy. This is an area in which strength in numbers is important. We encourage all members to review the CNA program and see the commitment being made to West Virginia Medicine.

Respectfully submitted,
Jack Leckie, M. D., *Chairman*

Committee on Medical Education and Hospitals

The past year (September to August) has produced considerable activity on the part of the West Virginia State Medical Association's Committee on Medical Education and Hospitals.

Since the early 1970s, this Committee has been the unit to execute Association responsibility for the accreditation of intrastate con-

tinuing medical education programs, primarily at community hospitals. In its role, the Association has been an arm of various national organizations, including the American Medical Association; the Liaison Committee on Continuing Medical Education, and now the multi-organization Accreditation Council for Continuing Medical Education.

This past year has seen Committee representatives and members of the Association staff resurvey for continued accreditation CME programs at Charleston Area Medical Center, Broaddus Hospital-Myers Clinic in Philippi, and the West Virginia Academy of Ophthalmology. In each instance, varying periods of additional accreditation resulted.

Surveyed as a new applicant for accreditation was City Hospital of Martinsburg—given initial, provisional approval. Being processed as this report was prepared was another new application from United Hospital Center in Clarksburg, while the year also will bring resurveys at Jackson General Hospital in Ripley, Veterans Administration Center in Martinsburg, Ohio Valley Medical Center/Wheeling Hospital, St. Francis Hospital in Charleston and Northern Panhandle Mental Health Center in Wheeling.

New Surveys

New surveys usually are conducted by an on-site team of two or three persons, with one member an Association staff representative, after completion by the organization being surveyed of a detailed questionnaire setting forth CME budgets, assigned administrative and education responsibilities, methods for evaluation of course material, etc. The new surveys are always conducted while a CME activity is in session.

A similar questionnaire is required in a resurvey, usually involving a one-physician site visit in which, among other things, a careful review is made of progress—including correction of previously noted defects—made in the preceding accreditation period.

First a subcommittee and then the full Committee on Medical Education and Hospitals are involved in a review of accreditation team findings and recommendations before the institutions or organizations are advised of the action taken. Accreditation can and should mean many things to facilities and physicians, including approval of CME programs for Category 1 credit toward the AMA Physician's Recognition Award.

This past year also has brought detailed review and comment by key Committee representatives, and the Association staff, on an all-but-final, and extensive, revision of the national essentials for accreditation of those institutions sponsoring CME programs. Essentials used in West Virginia are consistent with — and in some instances go a bit beyond — the national standards.

Also revised and strengthened this year has been the ACCME-developed protocol for recognition of state medical associations and/or societies as accrediting agencies for intrastate CME. The West Virginia State Medical Association can look forward in the near future to a visit from an ACCME team to determine how the Association is meeting the protocol criteria.

Pre-Survey Questionnaire

Such a visit will be preceded by a pre-survey questionnaire which must be completed and returned in time for full review by an ACCME representative prior to the actual site visit.

Working relationships with the national ACCME office in the Chicago area have been most satisfactory and productive. The Association was charged by its leadership, in the early 1970s, with developing a fair but demanding program for intrastate accreditation.

The road, over the years, has not been without growth problems and rough spots. In some instances, accreditation of institutions initially has been denied, or provisional approval removed. But the overall results appear solid and effective.

The commitment to the program is, if anything, stronger than ever, particularly in the light of the new essentials and protocol. That leads to a further confidence that the physician, staff and other investment not only is justified, but ranks as one of the most valuable services the Association can provide.

Respectfully submitted,
William O. McMillan, Jr., M. D., *Chairman*

Cancer Committee

The Cancer Committee met at the State Medical Association's Annual Meeting at the Greenbrier on August 27, 1982, and again in Charleston on January 23, 1983, during the 16th Mid-Winter Clinical Conference.

The State Cancer Registry was explored again, and again recommended for re-establishment. It was noted that cancer has been designated as a reportable disease.

The American Cancer Society's Caring and Sharing and Cancer Prevention programs con-

tinue to be successful throughout the state, and are endorsed by the Committee.

The Community Clinical Oncology Program Grant for West Virginia was submitted. Dr. Steven J. Jubelirer, the principal investigator at Charleston Division of West Virginia University Medical Center, has been notified of its approval and funding.

Fifteen new Cancer Liaison members of the American College of Surgeons were appointed by Doctor Watne, and others will continue to be appointed.

Respectfully submitted,
Alvin L. Watne, M. D., *Chairman*

Committee on Venereal Disease

The incidence of venereal disease in West Virginia for calendar year 1982 totalled 3,211 cases occurring in every county of the state. Case-related data revealed a level of 160 infections per 100,000. Gonorrhea represented 2,609 cases or a rate of 130 per 100,000. The incidence of venereal disease in West Virginia is most evident among the age group 15-29, which reportedly represented 80 per cent of the morbidity.

Other sexually transmitted diseases that are being observed frequently by practitioners are non-gonococcal urethritis/vaginitis and herpes simplex Type II. While NGU can be and is easily treatable, herpes is not. Increased incidence of these diseases as well as acquired immune deficiency syndrome (AIDS), which seems to be most prevalent nationally in the gay community but certainly involves other social and health-problem groups, may be a basis for future consideration to make these diseases reportable in West Virginia.

The statewide culture screening activity directed toward early detection of asymptomatic female gonorrhea victims provided 54,950 examinations in 1981-82; 804 young women of child-bearing age were found to have laboratory evidence of the disease. With this in mind, medical providers should consider strongly performing routine cervical gonorrhea cultures on females 15-40 years of age when doing pelvic workups, particularly in all prenatal patients both early as well as late in their pregnancy.

Inquiries regarding the medical/epidemiologic management of the sexually transmitted diseases can be addressed through a toll-free line within the state venereal disease program, 1-800-642-8244, or by calling your local health department.

Respectfully submitted,
Page H. Seekford, M. D., *Chairman*

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WVU Medical Center
–News–

Compiled from material furnished by the Medical Center News Service, Morgantown, W. Va.

School Of Medicine Faculty Promotions Announced

Twenty-five faculty members in the School of Medicine have been awarded promotions.

John E. Jones, WVU Vice-President for Health Sciences, announced the promotions which were approved by the West Virginia Board of Regents along with 22 others from the University Medical Center's three other schools.

Each school makes performance reviews based on teaching, research and service before the promotions recommendations are sent to the board.

Those promoted, effective July 1, in the School of Medicine were:

Soad Bekheit, Professor, Medicine; J. David Blaha, Associate Professor, Orthopedic Surgery; Eric Brestel, Associate Professor, Medicine; David B. Burr, Associate Professor, Anatomy; J. Richard Casuccio, Assistant Professor, Otolaryngology; Paul L. Clausell, Associate Professor, Behavioral Medicine and Psychiatry; Joseph Fontana, Associate Professor, Medicine; David F. Graf, Associate Professor, Anesthesiology; Marybeth Harris, Assistant Professor, Physical Therapy; Richard J. Head, Associate Professor, Pharmacology and Toxicology; Ellen Hrabovsky, Professor, Surgery; Michael Johnson, Associate Professor, Physiology.

Steven Jubelirer, Associate Professor, Medicine; Arthur E. Kelley, Associate Professor, Behavioral Medicine and Psychiatry; Darshan S. Kelley, Research Assistant Professor, Biochemistry; Richard E. Klabunde, Associate Professor, Physiology; Rolf F. Kletziem, Professor, Biochemistry; William W. Orr, Associate Professor, Behavioral Medicine and Psychiatry; John Petronis, Professor, Physical Therapy; Patrick Robinson, Associate Professor, Medicine; Joan T. Robison, Associate Professor, Behavioral Medicine and Psychiatry; Jamshid Tehranzadeh, Associate Professor, Radiology; George Tryfiates, Professor, Biochemistry; Irma Ullrich, Professor, Medicine; Mary J. Wimmer, Associate Professor, Biochemistry.

Use Of Laser Unblocks Airway In Lung Cancer Patient

Laser treatment to unblock the right main airway of a patient suffering from lung cancer has been used at WVU Medical Center with good results.

Drs. Harakh Dedhia and N. LeRoy Lapp, co-investigators, said that to their knowledge it was the first use in West Virginia of Nd-YAG laser phototherapy in lung cancer.

Doctor Dedhia is Associate Professor of Anesthesiology and Medicine, and Doctor Lapp is Professor of Medicine and Chief of the Pulmonary Medicine Section.

They said the patient had complete blockage of the right main bronchus where it joins the windpipe, and that the radiotherapists didn't want to treat the lung cancer because of the obstruction.

Faced Dilemma

"They felt they would either give too heavy a dose of radiation to the collapsed lung or would induce infection behind the obstruction, and she would be worse off than she was," Doctor Lapp explained.

"So they asked us to see if we could open that passage and give her some air in the right lung, which we were able to do in three treatments.

"After each treatment, we gave the patient a period of time to heal. When we looked at the treated area there was evidence of sloughing off of all black, dead tissue, and there was a smooth membrane covering the area, so there was some healing which had occurred as well."

Doctor Lapp cautioned, however, that the treatment is experimental and is limited to use in selected patients for whom surgery is not indicated.

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( ) Pediatrics
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(✓) Neurology
( ) Radiology
( ) Psychiatry
( ) Cardiology
(✓) Allergy
(✓) ENT
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(✓) General Surgery
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Third-Party News, Views and Program Concerns

FTC Okays Preferred Provider Group In New Jersey

In its first pronouncement on the subject, the Federal Trade Commission has given its tentative blessing to a proposed preferred provider organization (PPO) in New Jersey.

The advisory does not have the weight of law, and is not binding on courts, though courts do consider advisory opinions. It could be revoked at any time. In addition, PPOs have taken many forms, and clearance for the New Jersey PPO is not applicable to other types of PPOs.

The advisory is significant, however, in that it represents the FTC's first step into the cloudy issues surrounding the PPO concept, the American Medical Association commented.

The advisory that was issued went to Health Care Management Associates (HCMA), a Moorestown, New Jersey, consulting firm that is developing a PPO known as the Cooperating Provider Program. It said the FTC does not believe HCMA's proposed PPO would violate antitrust law.

HCMA Is Brokering Agent

HCMA sees itself as a brokering agent in the arrangement. It would contract with up to 15 per cent of individual physicians, oral surgeons, podiatrists and psychologists in three counties to provide care to patients covered under the plans of insurers or companies that sign up with HCMA.

In its advisory letter to HCMA, the FTC noted that "no actively practicing provider, hospital, or payer has any direct or indirect financial, controlling, or non-controlling interest in HCMA." It also carefully spelled out that the financial arrangements are to be between HCMA and each individual physician.

Those, according to FTC official Walter Winslow, are two aspects of HCMA's plan that set it apart from many other PPOs. The latter is particularly significant because it distinguished HCMA from the Maricopa Foundation in Arizona, which the Supreme Court ruled had engaged in price fixing by agreeing jointly on the maximum fees its members would seek.

FTC Also Approves Review Of Private Programs

The FTC also gave a Rhode Island Professional Standards Review Organization the go-ahead for its plan to review the medical necessity of care provided to private employers' health benefits programs.

The PSRO had asked the FTC in January for an advisory opinion on its plan to conduct preadmission and concurrent reviews of private patients, to recommend appropriate lengths of hospital stays and to conduct quality review studies. Its recommendations are not binding on the companies, and no fee reviews would be conducted under the program.

'Baby Doe' Rule Springs Back To Life

The U. S. Department of Health and Human Services has proposed a new version of the controversial "Baby Doe" rule requiring hospitals and clinics to post notices publicizing a 24-hour hotline to be used in cases of suspected neglect.

The original regulation was struck down in federal court last May.

The procedure, rather than the substance of the rule, is changed. It still contains the requirement to post notices listing the hotline number. But instead of requiring the posting of the notice in delivery, maternity, and intensive care wards, it requires that the notice must be posted in nursing stations. The new rule also will allow a longer public comment period.

The rule's long preamble and appendix specify that federal law "does not require the imposition of futile therapies which merely temporarily prolong the process of dying of an infant born terminally ill." The rule also attempts to define the term "handicap" as disorders such as "mental retardation, blindness, paralysis, deafness, or lack of limbs."

"Any judgment that a person is not worthy of treatment due to such handicap is not . . . a medical judgment, even if made by doctors . . . ," the rule says.

Obituaries

SANGA TANTULAVANICH, M. D.

Dr. Sanga Tantulavanich, Welch internist, was drowned on April 2 after heavy seas capsized the boat in which he was a passenger in the Gulf of Thailand.

Doctor Tantulavanich, 33, was one of eight persons drowned or originally missing in the accident: 22 others were rescued. The site was near the coastal city of Samut Prakan in Thailand.

A native of Bangkok, Thailand, Doctor Tantulavanich was a member of the staff of Stevens Clinic Hospital in Welch.

He was a member of the McDowell County Medical Society and the West Virginia State Medical Association.

County Societies

FAYETTE

Dr. Sidney Richman of Hartford, Connecticut, was the guest speaker for the meeting of the Fayette County Medical Society on June 1 at Montgomery General Hospital.

Doctor Richman's topic was "The Use of Beta-Blockers in Hypertension." He is a cardiologist and Associate Professor of Medicine at the University of Connecticut. — S. S. Maducdoc, Jr., M. D., Secretary-Treasurer.

CHANGE OF ADDRESS

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. The 1984 Roster of Members will be prepared and placed in the mails shortly after the first of the year and we would very much like for your correct address to appear in same. If applicable, to comply with recent U. S. Postal Service regulations, please include your P. O. Box number with zip code. Changes should be mailed to Box 1031, Charleston, West Virginia 25324.

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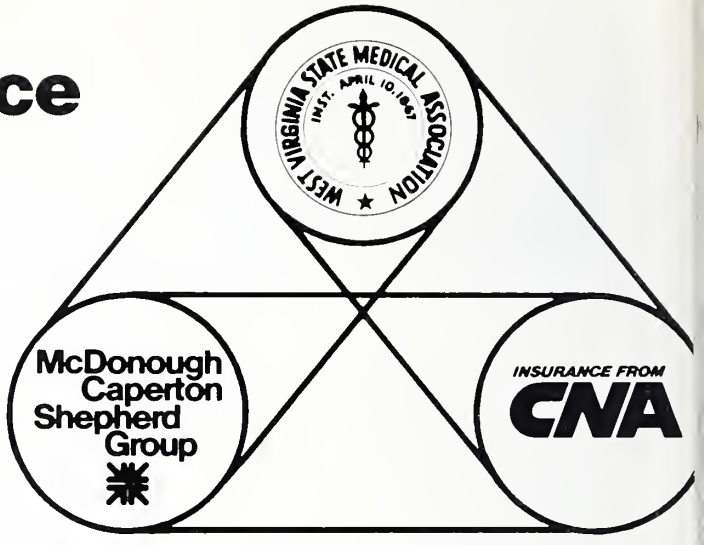

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Public Health Legacy of the Vietnam War: Post-Traumatic Stress Disorder and Implications for Appalachians*

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Team Leader, Huntington Veterans Center

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Suicide; child and spouse abuse; divorce; alcoholism and drug abuse; jail terms, and psychiatric and physical maladies are the public health legacy of the Vietnam War. Complex interacting factors account for the fact that West Virginians suffered the highest casualty rates during the war. It is conservatively estimated that 7,000 West Virginians continue to suffer from Post-Traumatic Stress Disorder (PTSD) in the aftermath of the war. The temptation has been for Americans to want to forget our longest war — one that we lost. It is a painful story.

If providers of medical and health care are to intervene successfully in this mammoth public health problem, the dynamics of its development must be understood.

Introduction

THIS paper is intended to explain the problems presently being experienced by some Vietnam veterans. It is an attempt to heighten the awareness of primary care providers and their colleagues so that the public can be better served.

Approximately 8.5 million individuals served in the military during the Vietnam era with 2.8 million being assigned to Southeast Asia from 1964 - 1973. Almost one million were engaged in active combat or were exposed to hostile, life-threatening situations (President's Commission on Mental Health, 1978). There are 29,000 Vietnam combat veterans in the state of West Virginia (Giles, 1981). A major problem has been to convince the public, both lay and professional, that Vietnam veterans indeed experienced a war that was unique in its situations and stresses. The nature of the Vietnam struggle has presented a unique set of problems to those who experienced it. Herein, it is hoped that the reasons for the uniqueness, and as such, the toll exacted on our countrymen and their families and friends can be clarified.

Just as defending our great nation is everyone's responsibility, so is it everyone's responsibility to recognize the defenders, their sacrifices, and provide them the sensitive treatment they need.

Combat as Stress: A Review of the Development of Current Theory

During World War I, specific clinical syndromes came to be associated with combat duty. Previously, such casualties had been dismissed as being a result of cowardice and poor discipline. The concept evolved that the high pressure of exploding shells caused actual physiologic damage precipitating symptoms labeled "shell shock." By the end of the war, the

*This paper was developed in conjunction with a special research project conducted through the Marshall University School of Medicine's Department of Psychiatry.

syndrome was being described as a "war neurosis" (Glass, 1969). As with any neurosis, the focus was that predisposing personality characteristics of the combatant were responsible for the reaction, rather than the traumatic experiences intrinsic to combat.

In the early years of World War II, psychiatric casualties had increased by 300 per cent compared to World War I, even though preinduction psychiatric rejection rate was four times greater than World War I (Figley, 1978). At one point in the war, the number of men being discharged from service for psychiatric reasons actually exceeded the number of men being drafted (Tiffany/Allerton, 1967).

Using the assumption that predispositional factors were the primary precipitant of combat psychological breakdown, it soon became apparent that not many soldiers would be immune. In fact, a 1944 Inspector General's report concluded: "If screening is to weed out all those likely to develop a psychiatric disorder, then all should be weeded out." The concept of war neurosis with an etiolgic basis on the pre-military history of combatant had outlived its usefulness. Hereafter, various intrinsic combat stresses were recognized as the basis of psychiatric decompensation (Figley, 1978).

The lessons of World War II were well learned. Due to the efforts of military psychiatrist Alber Glass (1954), combatants who suffered breakdown in Korea were dealt with in a very situational and usually on-site manner, with the expectation of speedy return to the combat unit. The results of the new perspective had immediate payoffs. During World War 11, 23 per cent of casualties evacuated suffered from a psychiatric malady whereas only 6 per cent of Korean War casualties were evacuated for psychiatric reasons (Bourne, 1970).

Suprisingly, in the Vietnam War, battlefield psychological casualties evolved in a new and unexpected direction. What was expected via past war experience (and what was prepared for) did not materialize. Battlefield psychological casualties were at an all time low of 1.2 per cent (Bourne, 1970). At the time it was thought that the use of preventive measures learned in Korea and added situational manipulations (to be discussed later) had solved the ancient problem of combat breakdown.

As the war continued for a number of years, some trends began to emerge. A previously obscure but well documented phenomenon of World War II began to be seen again. At the end of World War II, some men suffering from acute combat reaction, as well as their peers with no such symptoms, began to report common complaints, such as intense anxiety, battle dreams, depression, explosive agressive behavior, and problems with interpersonal relationships. These symptoms were found in five-year follow-up (Futterman and Pumpian-Mindlin, 1951) and 20-year follow-up studies (Archibald and Tuddenham, 1965).

Again in Vietnam, both those who had suffered from acute combat reaction and others who did not began to claim these same symptoms long after leaving the combat situation. What was unusual compared to previous wars was the large number of veterans reporting these symptoms. In previous wars, incidence of psychiatric casualties was observed to increase as intensity of the war increased, and correspondingly, the incidence decreased as the war intensity decreased. During Vietnam the pattern of reported psychiatric casualties differed; as combat intensity increased, there was no corresponding increases in the casualty rate. It was not until the early 70s, as the war was winding down, that incidence of psychiatric disorders began to increase. By 1973, with the end of direct American troop involvement, the number of veterans presenting with neuropsychiatric disorders mushroomed (President's Commission on Mental Health, 1978).

"On state-by-state analysis, West Virginians suffered the highest casualty rate in Vietnam with 85 men losing their life for every 100,000 males in the 1970 census."

During the 1970s, many civilian natural disasters had occurred (fires, earthquakes, plane crashes, etc.). The survivors of these catastrophies presented with problems strikingly similar to those of Vietnam veterans. After much research (Figley, 1978) by various veterans' task forces and recommendations by therapists involved with civilian post-traumatic problems, the Diagnostic and Statistical Manual III (DSM III), published in 1980, included a new category: Post-Traumatic Stress Disorder (Acute, Chronic and/or Delayed).

The acute subtype can be thought of as those disorders previously known as "shell shock" or "acute combat reaction." As noted, the incidence of this acute type, due to behavioral manipulations and unique circumstances of the Vietnam War, was very low. The chronic or delayed sub-

types have, however, taken on special significance with their recognition in veterans of the Vietnam War. PTSD (Delayed or Chronic) manifests itself in various insidious processes, and often may have been diagnosed as an individual personality disorder.

Features of Post-Traumatic Stress Disorder, Chronic or Delayed

Characteristic symptoms follow a psychologically traumatic event outside the range of usual human experiences (DSM III, 1980). Simple bereavement, chronic illness, business losses or marital conflict are considered within the usual realm of experience unlike rape or assault, military combat, natural disasters, serious car or plane accidents, torture or concentration camps.

PTSD can be variously expressed. Commonly the individual suffers intrusive, painful recollections or nightmares during which the stressful event is re-experienced. Rarely, dissociative states, lasting minutes to hours or days, occur during which the individual relives, and behaves as if experiencing, the original stressful event. Diminished responsiveness to external events referred to as "emotional anesthesia" or "psychic numbing" commonly begins soon after the stressor event. PTSD victims complain of feeling detached or estranged from previously significant life experiences (DSM III, 1980). Problems with intimacy, tenderness and sexuality are common. In fact, the majority of veterans at the Huntington Vet Center are experiencing marital difficulty (Giles, 1981). Many report this is a consequence of loss of affect, which they themselves relate to Vietnam combat experience. Exaggerated startle response or hyperalertness due to hyperautonomia follow the stressor. Phobic avoidance of situations that remind victims of the stressor is common. Hot, humid weather, helicopter noise, open spaces in fields surrounded by thick vegetation and "anniversary" reactions have been reported to stimulate exacerbation of symptoms. Anxiety and depression, explosive behavior with minimal or no provocation, inability to concentrate, and failing memory are all characteristic. Substance abuse and its milieu of accompanying complicating effects often develop.

The Vietnam Experience as Predisposing to Post-Traumatic Stress Disorder

Going into Vietnam, military planners used lessons of previous wars in an attempt to solve the huge problem of battlefield psychological breakdown. It was understood that men with the most combat exposure suffered the highest rate of breakdown.

The result was the DEROS system (date of expected return from overseas). All personnel knew upon leaving the United States when he or she would be rotated back stateside. All tours were 12 months except those for the Marines, who served 13 months. DEROS offered each individual a way out of the war other than as a physical or psychological casualty (Kormos, 1978). The advantage of the system was clear. If the individual could hold together for the predesignated time period, the promise of stateside rotation would be a way for the combatant to leave the war behind. The disadvantages of DEROS were not immediately clear. DEROS became a very personal thing as each person rotated on his own with his own specific date. This meant that the Vietnam experience became, for each person, a solitary, individual episode. It was rare, after the first few years of the war, for entire units to be sent to the war zone simultaneously. As Bourne noted (1970, p. 12), "The war becomes a highly individualized, encapsulated event for each man. His war begins the day he arrives in the country and ends the day he leaves." Bourne further asserts (p. 42), "He feels no continuity with those who precede or follow him. He even feels apart from those who are with him but rotating on a different schedule."

Unit morale, cohesion and identification suffered tremendously (Kormos, 1978). Studies from past wars (Grinker & Spiegel, 1945) point to unit integrity acting as a buffer for the individual against the overwhelming stresses of combat. World War II veterans commonly spent extended periods of weeks or months on "the long boat ride home." The importance of this is that the World War II veterans, in the context of the unit, were able to work through especially troubling combat experiences that they had been through together. In contrast, the Vietnam veteran had a solitary plane ride home and a head full of grief, joy, confusion and conflict. Many went from firefight to southern California in a period of 36 hours. Most made it stateside in less than one week.

For the Vietnam combatant the DEROS date became a fantasy that promised an end to all problems as he took the "freedom bird" stateside. In the "other world" context of Vietnam, individuals believed that neither they as individuals, nor the United States as a society, had changed in their absence. Hundreds of thousands

lived this daily fantasy as evidenced by the universal popularity of "short-timers calendars." "Short-timers" were GIs nearing an end of their Vietnam tour. The intricately designed calendars contained spaces for 365 days and they were openly displayed and cherished as "short time" approached. "Short-timers" were revered by their peers, and almost daily led their peers through fantasy ritual descriptions about how carefree life would be upon returning home. For the GI who was struggling with psychological breakdown due to the stresses of combat, the DEROS fantasy served as a major prophylactic to actual overt symptoms of acute combat reaction. The vast majority did hold on as evidenced by low psychiatric casualty rates during the war (President's Commission on Mental Health, 1978).

Struggle to Hold on Difficult

The struggle to hold on was difficult for most. Motivations that keep combatants fighting, unit esprit de corps, small group solidarity and an ideologic belief that this was the good and just fight were not present in Vietnam. Complete strangers, often GIs who were strangers to the speciality of the individual unit, were rotated in as others rotated out. Veterans who had reached a level of proficiency also had reached their DEROS date and were rotated. Green troops or "F.N.G.'s" (------- new guys) with poorly developed skills took their places. "New guys" were avoided by seasoned troops until they had a couple of months of experience because no short-timer wanted to get killed by relying on an inexperienced "F.N.G." It is obvious that endless arrivals and departures slashed unit culture and esprit.

It was a rare occurrence that Vietnam veterans wrote to their buddies still in the country (Howard, 1976). Survivors' feelings of guilt about leaving buddies behind to an unknown fate precluded the need to keep in touch (Goodwin, 1980). It is even rarer to see two or more getting together after the war. Contrast this to the continual reunions of World War II veterans.

Another unique factor of Vietnam was its guerrilla nature. In World War II, the U.S. was confronted by a uniformed, easily recognizable, foe. A focus of rage was therefore available to the World War II combatant. Vietnam was quite the opposite. The enemy was rarely uniformed. American troops were often forced to kill women and children combatants. There were no real geographic lines of demarcation. All land was contested and the entire country seemed hostile to the Americans. Surprise-firing booby traps became the unseen, most feared enemy tactic, in which the enemy himself was rarely sighted. The war to the combatant became an endless line of casualties and rotations with no land won or lost and a poorly identifiable foe. Rather than an ideologically justifiable experience, the war became a private war of survival to each American. Rage created by these situations was widespread among troops. It showed itself as violence and mistrust toward Vietnamese, toward authorities, and finally toward the society that had sent these troops and then failed to support them.

This also was America's first teenage war (Williams, 1979). The average age of the Vietnam combatant was 19.2 years while the average of World War II combatant was 26.4 years (Wilson, 1979). Developmental models point to this period for most adolescents involving psychosocial moratorium (Erikson, 1968) during which the individual takes time to build this enduring concept of self. This important step—identity vs. role confusion—was clearly disrupted

"The suicide rate is startling. A sobering fact is that by 1979 more Vietnam veterans had died by their own hand since the war than actually died in combat."

for the adolescent combatants via ambiguous roles and conflicting values associated with combat. This led to many subsequent problems. The early twenties becomes the time for resolving the conflict of "intimacy vs. isolation" (Erikson, 1968). Without resolution of "identity vs. role confusion," the individual is decidedly handicapped in resolving "intimacy vs. isolation."

Vietnam was the first war where tranquilizers and phenothiazines were therapeutically administered to combatants (Jones & Johnson, 1975). This allowed many who might have become acute combat reaction (shell shock) victims of earlier wars to continue to function until their DEROS date arrived.

Self-Medication Routine

Self-medication via cannibis or opiates was routine. The military viewpoint of opiate abuse was that the behavior was problematic, and opiates users were discharged administratively with diagnoses of character disorders (Kormos, 1978). Interestingly, cannibis users did not seem to contribute to a lack of readiness or an increase in psychiatric problems. Quite to the

contrary, cannibis seemed to serve a medicinal purpose and work as a buffer in submerging and delaying symptoms of acute combat reaction (Horowitz and Solomon, 1975).

Finally, when the Vietnam veteran did get home, his DEROS fantasy was quickly replaced by harsh reality. The civilian population of World War II had been exposed to movies about the struggle of readjustment by veterans; witness "The Man in The Grey Flannel Suit;" "The Pride of the Marines," and "The Best Years of Our Lives." These movies gave the civilian population a context in which to consider the returning veteran (DeFazio, 1978). On the other hand, the civilian population of the Vietnam era had been relentlessly exposed via television's six o'clock news to the horrors of war. They were angry, tired and numb. America was not ready psychologically or socially to welcome home Vietnam veterans.

Returning Vietnam veterans found a confused, divided country. They had not returned victors in any struggle—military, ideologic, psychologic or social. Their world had indeed changed, and they also had been changed.

What they experienced in Vietnam and upon return will leave a mark that they may never erase. To this author, one veteran summed it up when he said, "I will go on and try to enjoy life again, but I will never be young again . . . they stole my youth."

Where Were Vietnam Veterans in 1981?

In a discussion of the purpose of the paper with a physican who heads the emergency room very near the West Virginia Veterans Administration Center in Huntington, he expressed doubt that problem-ridden veterans often are seen in that facility. His comment was, "We don't see many Vietnam veterans with emotional problems." This remark has allowed the authors to understand that he (and certainly others) are oversimplifying a huge and complex public health problem that goes far beyond "emotional problems." Manifestations of PTSD are diffuse and, taken out of context, often are unrecognized as a part of the syndrome.

To assist practitioners in gathering pertinent information from their patients, it is necessary to give some insight into the type of lives that these veterans were leading in 1981. Unemployment had become a major problem for these veterans. Many felt betrayed in that draft resisters and nonveterans in their age group were able to continue non-interrupted career and educational tracks. Black and socioeconomically disadvantaged veterans have less effective peer support and, as such, have been especially vulnerable to unemployment's special stresses. The temptation is to contend that these individuals, regardless of military experience, would occupy the same rung on the career ladder. However, when background and educational differences are controlled statistically, veterans still show residual disadvantage in education and occupational attainment (Rothbart & Sloan, 1981). Vietnam-era veterans as well as Vietnam combat veterans exhibit this phenomenon although the disadvantages are especially pronounced in combat veterans. When Vietnam-era and combat veterans are compared to their non-veteran peers, the striking conclusion has to be that military duty in Vietnam had a negative effect on post-military achievements (Rothbart & Sloan, 1981).

Now that most Vietnam veterans are in the age group of 30-38 years, it should be noted that future attainment of occupational goals probably has been irrevocably handicapped (Rothbart & Sloan, 1981).

Concerning the social and psychological problems of this group, it has become apparent that these men and women are especially troubled by problems of alienation, psychiatric symptoms, medical problems, drug and alcohol use and trouble with the law. Further, it should be understood that the Veterans Administration as the traditional provider of services to veterans has been utilized by only a small minority of veterans with medical problems. In fact, only about 37 per cent of Vietnam veterans with residual physical problems utilize the VA. These findings have been noted by at least two major studies including the 1970 National Survey of VA Utilization, and Lauffer, Frey-Wouter, Yager, 1981.

Depression a Common Problem

Depression is a common problem of combat veterans. Classic symptoms as described in the DSM III are the rule: sleep disturbances, psychomotor retardation, feelings of worthlessness, inability to concentrate and suicidal thoughts plague this group (Williams, 1979). Currently, black combat veterans, in fact, report stress symptoms at a rate of 70 per cent while white veterans report the symptoms at about a 33-per cent rate (Lauffer, Frey-Wouter, Yager, 1981). The suicide rate is startling. A sobering fact is that by 1979 more Vietnam veterans had died by their own hand since the war than actually died in combat (Williams, 1979).

Isolation is a defense adopted by many veterans of the Vietnam War. Combat veterans have few friends. Many veterans have been able to isolate themselves by repeatedly moving from one geographic location to another, imposing an immense stress on their families in the process. It is not rare to find combat veterans who have not had social contact with women for years. Even those that are married impose rigid isolation on their wives and children. Ineffective resolution of "intimacy vs. isolation" (Erikson, 1968) due to having to rely only on one's self to survive the combat situation, as well as the readjustment to civilian life in a society appearing apathetic, if not openly hostile, has reinforced this attitude that the veteran can trust only himself in life. Veterans have actually taken weapons and attempted to live off the land in isolated areas of the Rocky Mountains (Williams, 1979). Lynda Vandevanter of Vietnam Veterans of America reported that upon the opening of the Anchorage, Alaska, Veterans Outreach Center, several Vietnam veterans appeared who claimed to have lived for years in Alaska's wilderness as hermits.

Rage is a problem plaguing these men and their contacts. Many have been known to strike out violently at those around them, including wives and children. These frightening episodes lead many veterans to question their own sanity around this issue. The antennae of the careful diagnostician should raise there. Child or spouse-abuse problems should provoke a high index of suspicion when the father (or mother) is in the age group that could include Vietnam veterans.

Wilson (1979), using his model of Eriksonian psychosocial development, estimates that problems with this group should increase in incidence until 1985 when men and women in the group will be moving on to resolution of the next stage of psychosocial conflict.

The legacy of an unresolved conflict in the minds of Vietnam veterans promises the existence of a huge and lingering public health challenge for at least the last two decades of the twentieth century.

Appalachia and Post-Traumatic Stress Disorder

Epidemiologic research indicates that West Virginia specifically, and Appalachia in general, have a higher prevalence of PTSD than any other region of the United States (Giles, 1981). The primary reason for this is the high rate at which Appalachians were placed in the most lethal combat roles. On state-by-state analysis, West Virginians suffered the highest casualty rate in Vietnam with 85 men losing their life for every 100,000 males in the 1970 census. This compares to a national average rate of 55 per 100,000 males. Based on actual rates, it is possible to estimate conservatively that there are 7,000 West Virginians suffering from PTSD.[1]

On a national level, men from rural states were twice as likely to be sent to Vietnam as were men from highly urban states (Giles, 1981). Casualty rates were generally much higher for rural states than urban states.[2] Statistical review of Ohio and Kentucky both revealed that Appalachian counties had casualty rates significantly higher than other rural counties and nearly twice that of urbanized areas.

The reasons for this epidemic of PTSD in West Virginians are worth speculating about. West Virginia has always revered veterans, and was generally isolated from the mainstream of anti-war sentiment. The military appeared to present many options and valuable training for young men living in a region of limited vocational opportunities. West Virginians are patriotic and

"Based on actual rates, it is possible to estimate conservatively that there are 7,000 West Virginians suffering from PTSD."

have a long heritage of service during war. The emotional step from family-oriented to military service is relatively easy for Appalachians. It represents one of the few accepted ways of emancipation from the family.

Rural men in general, and West Virginians specifically, are pre-trained to be good combat soldiers. Most have hunted at some time in their lives and are comfortable in the woods and with weapons. Their family orientation has left them with an assumption toward respecting authority.

1. Studies by Wilson (1979) and Egendorf (1981) as well as VA estimates all suggest that there are from 500,000 to one million veterans suffering from PTSD. Research has shown that the best predictor of PTSD is combat exposure. Casualty rates are also highly correlated with combat exposure. An assumption is made, based on these correlations, that the best estimate of prevalence based on geography can be gained by reviewing casualty rates. The authors feel that, conservatively, there are 10 veterans suffering from PTSD for every casualty, and that they reflect the same demography as do casualties. This would mean an estimated 570,000 cases nationwide based on 57,000 casualties. This would mean somewhat over 7,000 PTSD cases for the 711 West Virginians who were killed in Vietnam.

2. "Rural" is defined as states with less than 40 per cent of the population living in cities. Urban states were those with over 80 per cent of the population living in cities.

The military is aware of these factors and historically has "funneled" Appalachians into combat roles. It is simple personnel psychology. Put the right man in the right job.

In Appalachia, there are many commonly held values that must be considered when health care services are provided. Weller (1965) has pointed out that mountain people have strong negative attitudes about people who work in the helping professions. He further states that Appalachians are afraid of illness and that they delay getting care for fear that something may be wrong with them. "What is said about sickness in general is all the truer for mental illness; the Mountaineer cannot accept it. 'Poor nerves' or 'worn out nerves' can be blamed for such disturbances" (p. 119).

Emphasis on Personal Relationships

Appalachians emphasize personal and face-to-face relationships, and are confused by the impersonal components of health care delivery. The Appalachian fears those health care providers who use complicated language, rigid time schedules, and uncertain explanations.

In *Everything in Its Path*, an excellent study on the effects of the Buffalo Creek flood, which killed 125 West Virginians and destroyed their community in February, 1972, Kai Erickson (1976) describes many of the values that influence Appalachians' reaction to stress and responsiveness to help.

A primary coping strategy of Appalachians, according to Erikson, is a pervasive fatalism. Other experts on this region have observed the same characteristic. Weller (1965) writes: "The sense of fatalism that runs through all of life comes into prominent play in medicine . . . (It provides) a cushion for the mountaineer's heart against the rough times of his life—the death of the children, the killing of the husbands in the mines or woods" (p. 120). And war.

This passivity or sense of resignation in the face of misfortune is a cultural adaption to the physical and economic hardships of the region and the lack of control over events. The numbing caused by exposure to trauma in Vietnam often does not generate a great deal of concern in Appalachia. It often is labeled as bad nerves, and may only become a treatment concern when the symptoms become very severe.

Bad nerves is rapidly becoming a prevalent, culturally accepted form of self-diagnosis for certain disabling conditions. It is basically a medical model or somatic notion that something is physically malfunctioning.

According to Erickson (1976), "the fear of disability has become a prominent theme in (Appalachian) thinking" (p. 87). He suggests that because of their history of physical sturdiness and survival ability, Appalachians have been preoccupied by physical health. Like others who share this concern (athletes, dancers, beauty contestants), their major apprehension is about their health, and they are consumed with concerns about their aches and pains.

The Role of the Primary Care Physician

An in-depth discussion of therapeutic intervention is beyond the scope of this paper. However, the authors hope to follow up with just such a discussion. Often the primary care practitioner has neither the training nor time to attempt to unravel the complex problems of individuals in this group. Traditional psychotherapeutic methods have not yielded positive results. A mass of literature points to the "rap group" concept of veterans getting together to "work through" the Vietnam experience as the most promising form of treatment (Egendorf, 1981).

Across the United States, 133 storefront Vet Centers that are staffed with specialists in dealing with Vietnam veterans with PTSD have been established. In West Virginia, there are offices in Charleston, Huntington and Morgantown. These centers offer counseling as well as providing a channel of referral for Vietnam veterans into the community health resources. They provide help with discharge review, veterans' benefits, legal aid and family counseling.

Questioning the veteran about possible combat exposure is essential in making the diagnosis and often helpful in establishing rapport with the patient. If the individual is a veteran who feels that the combat exposure may be related to his problems, the practitioner should consider a Vet Center as a referral source. The practitioner can appreciate that only the cooperative, willing veteran is a good candidate for psychotherapy. In-depth probing of specific combat experiences may be counter-productive and indeed dangerous if not skillfully handled. Medicinal therapy is also fraught with hazard if not administered as part of a total psychological regimen. Yost (1980) warns that use of psychotropic medications must be avoided whenever possible.

Treatment modalities are currently under evaluation. This lack of a standardized treatment plan often makes contact with the Vietnam veteran a frustrating experience for the primary care provider. In cases where prospects for successful referral are not good, care providers are

encouraged to maintain ongoing contact even though tenuous due to the high-risk nature of this group.

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Practical Tips On Adverse Drug Effects In Glaucoma Therapy*

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There are four major groups of drugs utilized by the ophthalmologist for managing glaucoma outpatients. They are parasympathomimetics, sympathomimetics, carbonic anhydrase inhibitors, and beta-adrenergic receptor blocking agents. Although the route of administration in three of these classes of drugs (all groups except carbonic anhydrase inhibitors) is topical, there can be systemic absorption through the lacrimal drainage system to produce significant systemic side effects. The fourth group, carbonic anhydrase inhibitors, also may have potentially serious side effects.

Seven clinical situations are presented for the practitioner managing patients who are taking antiglaucoma medications. The primary care physician is urged to maintain a high index of suspicion and be alert to these side effects in glaucoma patients taking these agents. The physician should consult closely with the patient's ophthalmologist in managing systemic complications from glaucoma medications.

Seven Clinical Situations

1. The patient's presenting complaint is frontal headache. The physicial examination reveals miotic and fixed pupils. The patient is likely using a topical parasympathomimetic preparation for treatment of open-angle glaucoma. Parasympathomimetics may cause blurred vision and pain in the supraorbital and frontal areas. The miotic medication may be responsible for the patient's complaint.

2. The patient's complaint is cramping, nausea, and diarrhea. Physical examination reveals miotic pupils. The miosis may be due to topical anticholinesterase therapy for open-angle glaucoma which also may be producing these cholinergic systemic side effects.

3. A patient who has been on chronic anticholinesterase therapy for glaucoma may experience prolonged apnea in the postanesthetic period if succinylcholine is utilized in induction. The anesthesiologist should be alerted.

4. A patient with open-angle glaucoma who is being managed for hypertension should be questioned carefully about antiglaucoma medications. Chronic use of topical epinephrine may aggravate his hypertension. Dipivefrin (a prodrug) should be substituted in this situation, virtually eliminating the adverse effect of epinephrine on blood pressure.

5. Carbonic anhydrase inhibitors may cause chronic gastrointestinal upset, parasthesias, and weight loss. Occasionally, a glaucoma patient who is being maintained on one of these medications (Diamox, e.g.) is hospitalized and investigated for neurologic disease or malignancy. The patient with glaucoma and these symptoms should be questioned carefully about the use of carbonic anhydrase inhibitors. An unnecessary and costly workup may be avoided if it is known that one of these drugs is responsible for the patient's complaints.

6. Carbonic anhydrase inhibitors may precipitate renal calculi. They should be discontinued in patients with a positive family or personal history for kidney stones. Close cooperation with the patient's ophthalmologist is encouraged for optimum patient care.

7. A glaucoma patient who presents for evaluation of dyspnea should be questioned about the use of topical timolol maleate. This beta-receptor blocking agent may precipitate or aggravate dyspnea in chronic obstructive pulmonary disease, congestive heart failure, and bronchial asthma.

Background Data

Glaucoma is the number one cause of legal blindness in the United States. It was responsible for 12.5 per cent of all legal blindness in 1978.[1] While it is not a major blinding disease in the under-45 age group, it becomes a major cause of blindness after 45. The National Society to Prevent Blindness estimated that 62,100 individuals were blind from glaucoma in 1978. The prevalence rate of glaucoma rises sharply in the seventh decade. The prevalence rate is 27.7/100,000 population in the 45 to 64 age group for both sexes. The rate rises sharply

*This paper was written while Doctor Schwab was Assistant Professor, Department of Ophthalmology, West Virginia University School of Medicine, Morgantown.

to 115.5/100,000 population in the 65 to 74 age group, and 290.0/100,000 in the 75 to 84 age group.

It is obvious that glaucoma is a common ophthalmic problem in the geriatric population. Many geriatric patients managed for chronic cardiovascular illness also may be treated for open-angle glaucoma. Many medications used by the ophthalmologist in treating glaucoma have potentially serious systemic side effects, particularly in the geriatric patient with cardiovascular disease including hypertension.

Classes of Glaucoma Agents and Pharmacologic Actions

Pharmacologic agents for the management of glaucoma may be divided into five groups: parasympathomimetics, sympathomimetics, carbonic anhydrase inhibitors, beta-adrenergic blocking agents, and osmotic agents. Let us examine each group separately, with emphasis on systemic side effects and adverse drug reactions. We will not consider the local ocular side effects.

Parasympathomimetics:

Three types of parasympathomimetic agents are used widely in treating glaucoma patients: cholinomimetic alkaloids (pilocarpine); cholinesters (carbachol); and cholinesterase inhibitors (echothiophate iodide, isoflurophate, demecarium, and physostigmine).

Pilocarpine, a cholinomimetic, is a safe, inexpensive, and widely-used topical miotic. The cholinesterase inhibitors are potentially toxic. Potential side effects with these agents include possible "cholinergic crisis." This should be suspected if the patient exhibits lacrimation, salivation, nausea, vomiting, diarrhea, and diaphoresis. A history of recent administration of a topical anticholinesterase should alert the practitioner to this diagnosis.

There also is a risk of anesthetic catastrophe in patients who have been treated chronically with anticholinesterases. Because of the presence of pseudocholinesterases in these patients, succinylcholine may not be degraded in the postanesthetic period, and prolonged apnea may result. The use of succinylcholine in general anesthesia in patients on anticholinesterases should be undertaken with caution. If the patient is being treated with an anticholinesterase agent and is to undergo general anesthesia, alert the anesthesiologist.[2]

Sympathomimetics:

Sympathomimetics include epinephrine and dipivefrin hydrochloride. Epinephrine hydrochloride and epinephrine bitrate one- and two-per cent solutions, administered topically every eight hours, reduced the formation of aqueous by the ciliary body epithelium. They have little dilating effect on the pupil (mydriasis). Topical epinephrine solution may be absorbed systemically through the lacrimal drainage system and aggravate or cause hypertension.

Topical epinephrine compounds should not be used in geriatric patients with hypertension and cardiac arrhythmias. Elderly patients who are being treated with digitalis preparations and diuretics may be potassium depleted. A serious and possibly life-threatening arrhythmia may be precipitated by the administration of small amounts of topical epinephrine in potassium-depleted patients. Cerebral vascular accident and myocardial infarction are potential risks in patients with hypertension who are treated with topical epinephrine.

Dipivefrin hydrochloride may be used to advantage in glaucoma patients who respond to sympathometics. This agent is a prodrug and is not converted to its active form until it is absorbed intraocularly.[3] The systemic side effects of topical epinephrine may thus be avoided.

Carbonic Anhydrase Inhibitors:

Carbonic anhydrase inhibitors include acetazolamide (Diamox®), methazolamide, dichlorpehnamide, and ethoxzolamide. Of this group, acetazolamide (Diamox) is the most widely-used agent. These preparations are available in tablet and capsule form, and Diamox is available as a sequel preparation.

Diamox was used as a diuretic in hypertension prior to the development of more specific and effective diuretics. It reduces the production of aqueous fluid by the ciliary body epithelium by as much as 50 per cent.

Side effects and adverse reactions from carbonic anhydrase inhibitors are numerous. They include: paresthesias in extremities and digits; gastrointestinal disturbances including nausea, dyspepsia, cramps, and diarrhea; fatigue, weight loss, and malaise; decreased libido, impotence, and depression; exfoliative dermatitis; and Stevens-Johnson syndrome. Carbonic anhydrase inhibitors alkalinize the urine and cause metabolic acidosis.

The pharmacotherapeutics of glaucoma have improved dramatically in recent years with the development of new and effective antiglaucoma agents. Fewer patients with open-angle glaucoma are maintained long-term on carbonic anhydrase inhibitors. These drugs are now used mainly in acute (angle-closure) glaucoma and prior to intraocular surgery.

Beta-Adrenergic Receptor Blocking Agents:

The development of an effective anti-ocular hypertensive beta-adrenergic receptor blocking agent was an exciting new breakthrough in ocular pharmacology. Timolol maleate (Timoptic) is available in concentrations of 0.25-per cent and 0.5-per cent solutions; it is administered topically every 12 hours.[4] It reduces intraocular pressure by decreasing the rate of formation of aqueous by the ciliary body epithelium[5]; it also may increase the outflow of aqueous from the anterior chamber. It has no effect on accommodation or pupillary size.

Timolol maleate may produce general side effects of bradycardia and lowered blood pressure when it is absorbed systemically through the lacrimal drainage system. Bronchospasm also may be a side effect. This agent is contraindicated in patients with congestive heart failure, bronchial asthma, and chronic obstructive pulmonary disease.

Drugs Which Don't Affect Glaucoma

The *Physicians' Desk Reference* and package inserts for numerous medications warn of the risk of glaucoma with systemic administration. These drugs include the antispasmotics, the antihistamines, and the antiparkinsonian agents. Rarely, if ever, do these drugs produce ocular hypertension or glaucoma.

Several agents potentially may have minimal pupillary-dilating effect. A dilated pupil may precipitate an attack in a patient with a history of angle-closure glaucoma. This event would be more likely if the agent is administered topically to the eye. When used systemically, however, it has practically no effect on the pupil.

Atropine sulfate administered systemically preoperatively almost never precipitates an attack of angle-closure glaucoma.

It also should be noted that the drugs in these three groups have no effect on open-angle glaucoma.

Conclusions

The drugs used by ophthalmologists in managing glaucoma may have potentially serious systemic side effects. Glaucoma patients may not associate their systemic complaints with their glaucoma treatment regimen; consequently, these complaints may then come to the attention of the general physician.

There are four major drug groups widely utilized for glaucoma management. Side effects and complications among these medications are varied, and some are potentially life-threatening.

Antispasmotics, antihistamines, and antiparkinsonian drugs may be used when indicated systemically without the risk of precipitating angle-closure glaucoma.

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A message from . . .

The President

STRATEGY FOR CHANGE

It is with anticipation, excitement and apprehension that I begin to serve my year as your President. I do appreciate this opportunity and will need the cooperation and support of the membership if we are to be successful.

During the next 12 months, I will be using this page to address specific issues that will be of major concern to the Association and to the practice of Medicine. One of the paramount concerns will be to develop a framework of analysis so that a strategy can be formulated to deal with the changing structure of the health care system.

It is obvious that the emerging structure will be far different from the traditional private practice model. It will be very difficult for solo physicians to compete in the future marketplace: in fact, large groups may be necessary to compete effectively with health maintenance organizations, urgent care centers, and proprietary clinics managed by the large hospital corporations.

The concept of DRGs must be understood and incorporated into the planning process. Competitive bidding (contract negotiations) will be required as government agencies and corporations begin to apply pressure for medical services to be responsive to the law of supply and demand. The emergence of non-physician providers will continue to escalate. Competition between hospitals and their medical staff will be intense and will be amplified by the physician surplus of the next decade. The list goes on and on. . . .

Physicians must not be passive in adapting to these changes. They must be aggressive and develop long-range plans which will be formulated after careful consideration of the relevant factors. These plans must be developed now. Otherwise, physicians will be constantly reacting to each isolated change in the medical structure.

I hope that your State Association will be able to provide assistance and suggestions to the membership in developing future strategies. Perhaps my most important role over the next year will be to serve as a catalyst as these various changes are discussed, and together we plan a strategy for change.

Carl R. Adkins

Carl R. Adkins, M. D., *President*
West Virginia State Medical Association

The West Virginia Medical Journal

Editorials

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author shall be held entirely responsible. Editorials printed in The Journal do not necessarily reflect the official position of the West Virginia State Medical Association.

Starting with a hospital's first cost-reporting period after October 1, a diagnosis-related groups (DRG) reimbursement system goes into effect for inpatient Medicare reimbursement. Congressional action as of last March provides for phasing in DRG payments over three years.

Before enactment of the legislation, the American Medical Association and others called for controlled experimentation with this system, as well as others, before national implementation. But the DRG arrangement was enacted despite any reliable data about how it really will work over a long period of time.

DRG CONCERNS

Because the untested nature of the mechanism raises concerns about any number of things, including a most important potential effect on accessibility and quality of care, a need for further study of the DRG system remains as strong as ever.

The question is, will such a study be conducted, and by whom and how? What about a concern that hospitals, as a group, will have no incentive to improve efficiency under a DRG system because such improvements might lead to a reassessment and lowering of the overall reimbursement level?

Will hospital management place pressure on a medical staff to tailor length of stay and utilization of hospital resources to a patient's DRG? Will the system create incentives to increase reimbursement by upgrading the severity of admitting diagnoses in a practice which has been labeled "DRG creep?"

These are very real and critical questions with respect to DRGs, which provide a system that sorts patients into diagnostic categories that at least theoretically are medically similar and have an anticipated equivalent length of stay.

Under such a reimbursement system, insurers and other purchasers of hospital care pay a single amount for the treatment of an illness, regardless of variations in specific services provided to patients with the same diagnosis. Payment is linked directly to the average cost of treating a particular condition.

Against this general background, it's logical to see why the questions above can, and should, be raised. The federal legislation also contains, it must be stressed, a provision that could pave the way for extending the DRG concept to physician charges for inpatient hospital services provided Medicare beneficiaries.

Another major question is whether DRGs can demonstrate adequately an effectiveness as a way of paying hospitals, let alone physicians. Further, will the system shift Medicare costs to the private sector, and will initial and continuing administrative costs for hospitals exceed the anticipated cost savings, since only 25 per cent of the average hospital caseload is made up of Medicare beneficiaries?

These are very real concerns, and the position of the AMA, among others, is exactly right. A need for further study of this whole concept, despite Congress' action in setting up DRGs for Medicare, is undiminished.

Contrary to an all-too-popular view, West Virginia is not always last—at least, not in everything. With strong State Medical Association support, the Legislature enacted in 1981 a statute to require the use of approved restraint systems for children riding in motor vehicles.

The state followed close on the heels of Tennessee, where such protective legislation for infants first became law. As of April of this year, 31 states and the District of Columbia had child passenger safety laws; five legislative acts were on governors' desks for action, and virtually all other states had bills in the legislative process either to establish such restraints or tighten existing laws.

CHILD SAFETY

According to the National Safety Council, the highest infant death rate resulting from motor vehicle accidents occurs in the first year of life,

particularly the first six months. It counted at least 720 deaths and 2,900 injuries in 1981 among children under five.

The West Virginia statute requiring an approved restraint system stipulates a car bed or a car seat for a child up to age three, with a seat belt deemed sufficient for one between the age of three and five.

Others, such as safety councils and the American Academy of Pediatrics, likewise have played key roles in the child restraint program. Strong support has come from the American Medical Association's House of Delegates.

Much remains to be done to educate parents, in particular, in the area of child passenger safety. Automobile clubs have taken a lead role in this effort, including making approved car seats and the like available to vehicle owners. In this general concern, West Virginia has been a leader.

A number of West Virginia physicians know William Guillette, M. D. The former general practitioner who now is vice president of a national consultant-actuary firm was for 18 years with Aetna Life and Casualty, where he was medical director of the casualty and group-health claim departments.

SUCCESSFUL COST CONTROL PROVIDER-MOTIVATED

Doctor Guillette recently composed quite a lengthy piece on keys to containing health care costs. It was enlightening, bluntly but thoroughly presented, and, yes, it probably raised the hackles of some of his colleagues. Much of the material probably had been presented in similar detail before, but it still provoked some thought.

For example, Doctor Guillette noted that of all the payment-control programs he mentioned in his article, the ones that were the most successful in controlling health care costs were motivated primarily *by the provider*—not by the consumer or the employer. He cited the two most successful as a well-run Health Maintenance Organization (HMO) and ambulatory surgery.

How have quality HMOs led the pack in providing good health care and containing costs? "By controlling hospitalizations; more specifically, by avoiding unnecessary hospitalizations," Doctor Guillette said.

"Once an HMO patient is hospitalized, his or her length of stay generally is about the same as for non-HMO patients," he added. "It is by avoiding hospitalization — by encouraging extensive ambulatory serivces — that the big savings are achieved."

"The other major payment-control program that has the capacity to save significant dollars is ambulatory surgery, a concept that was pioneered by two anesthesiologists in Phoenix," Doctor Guillette continued. He then explained:

"Hospitals balked at offering this alternative, until the proliferation of ambulatory surgical centers—started by physicians—convinced them that they had best get into the act.

"The newest example of the changing marketplace is the development of the preferred-provider organizations put together by physicians and hospitals. They offer discounts on their services, in return for prompt payment and access to more patients.

"Why have these programs been so much more successful than second opinions, pre-admission authorizations, or PSROs? Very simply, because most of the other programs were proposed by government agencies or by insurance companies, and jammed down the physicians' throats. And, as stated earlier, none of these programs will work without the full cooperation of the medical community.

"Cost-containment programs must be structured to motivate both the doctor and the patient to want to do things economically — without sacrificing quality. Some would say that these two goals are incompatible; I say not. As evidence, I refer you to the many fine medical institutions which are currently offering high-quality care at competitive prices."

'POSITIVE FUTURIST'

Robert P. Johnson, M. D., President of the Illinois State Medical Society, thinks the "positive futurist" doctor must have a keen recognition of marketplace influences; and accommodate overall government spending reductions as well as less first-dollar health insurance coverage.

He or she will anticipate greater business efforts to cut health care costs, and reconfiguration of the overall medical care delivery system. Better understanding of the changing environment, and contingency plans for delivering medical care, will be essential.

The "positive futurist" M. D. will learn to forecast events; prepare personal blueprints; adjust to a more competitive marketplace—and stay flexible. "These skills will enable the doctor to meet the challenges of Medicine in the decades to come," Doctor Johnson predicts.

GENERAL NEWS

Parkinsonism, Disability Topics In 17th Mid-Winter Lineup

Parkinsonism and organic brain syndrome will be among subjects discussed during the 17th Mid-Winter Clinical Conference next January 27-29 in Charleston.

Opening Friday afternoon, January 27, and ending at noon on Sunday, the annual continuing education event again is being sponsored by the State Medical Association and the Marshall University and West Virginia University Schools of Medicine. The site, for the second year, will be the Marriott Hotel.

Albert F. Heck, M. D.

Among other CME offerings being planned for the three-day affair by the Program Committee will be a special Saturday afternoon session on "Into and Out of the Disability Trap," an in-depth panel discussion, emphasizing audience participation, on the physician and procedures and pitfalls in disability determination.

Preliminary plans for the disability program call for a physician moderator, with a panel including an employer's attorney, an attorney familiar with claimants' cases, disability officials from state and federal agencies, and an independent rehabilitation representative.

The Parkinsonism-organic brain syndrome paper will be presented by Dr. Albert F. Heck, Charleston neurologist, during the Saturday morning session. Doctor Heck is Clinical Professor of Neurology, WVU Medical Center, Charleston Division, and staff neurologist at Charleston Area Medical Center.

Other Topics

Other program topics planned by the Program Committee include AIDS; handling of children from broken homes; flexible sigmoidoscopy; seizures; geriatric pharmacology; new treatment in disc diseases; arthritis; and streptokinase in the treatment of heart disease.

Plans for the annual Friday evening physicians' session have not yet been announced.

Help for rape and incest victims will be explored during the Friday evening public session.

Prior to coming to Charleston in 1982, Doctor Heck was Professor and Chairman, Department of Neurology, University of Tennessee, and Director, Neurosciences Program, University of Tennessee Center for Health Sciences, in Memphis. He also was Director of the Neurology Residency Training Program at the University.

A native of Baltimore, Doctor Heck was graduated from Johns Hopkins University, and received his M. D. degree in 1958 from the University of Maryland. He interned at Mercy Hospital in Baltimore, and took his residency in neurology at the National Institutes of Health and the University of Maryland. He was certified in 1966.

Doctor Heck is a member of Alpha Omega Alpha Honor Medical Society, and a Fellow of the American Academy of Neurology, the Stroke Council, American Heart Association, and the International College of Angiology.

Teaching, Other Posts

He held several teaching positions, rising to the rank of Professor of Neurology, at the University of Maryland before going to the University of Tennessee in 1977. Currently, he is Senior Editor and a member of the Publications Committee for *Vascular Medicine*, and Vice President of the American College of Angiology.

Doctor Heck is the author of three book chapters, and the author or co-author of 54 abstracts and articles.

Members of the Program Committee are Drs. Joseph T. Skaggs, Chairman, William O. McMillan, Jr., and C. Carl Tully, all of Charleston; Maurice A. Mufson, Huntington; Robert L. Smith, Morgantown, and Richard G. Starr, Beckley.

The Committee receives continuing assistance from WVU Charleston Division staff members J.

Zeb Wright, Ph.D., Coordinator of Continuing Education, Department of Community Medicine; and Sharon A. Hall, Conference Coordinator.

More information concerning other speakers and subjects will be provided by the Program Committee in upcoming issues of *The Journal.*

Marshall Entering Class Has 48 Students

Fourteen West Virginia counties are represented in the Marshall University School of Medicine entering class, according to Cynthia Warren, Assistant Director of Admissions.

The 48-member class also will include two residents from Ohio and one each from Kentucky and Virginia.

"One of the most interesting things about this year's entering class is its age — the average age is 26.1 years, quite a jump over last year's average age of 24.9 years," Ms. Warren said. "We have new students as young as 21 and as old as 41."

She reported that the school's Admissions Committee interviewed 224 of 490 applicants. Of the 48 chosen, 35 are male and 13 female. Thirty-five students are starting with bachelor's degrees, 10 with master's degrees and three with doctoral degrees (two of them pending).

Six West Virginia colleges and universities are represented in the class: Marshall, West Virginia University, West Virginia State College, Fairmont State College, the University of Charleston, and West Virginia Wesleyan College.

The students and their hometowns are:

Cabell: Pamela G. Bailey, Barbara Bolton, D. Diane Bowen, Nancy L. Graham, Darlene Y. Gruetter, Christopher E. Hayner, James T. Holbrook, Allen B. Joseph, David C. Kowalski, Robert E. Mehl, Jr., Manuel E. Molina, Jose A. Ottaviano, Mark F. Sheridan, Bartlett A. Stone, Glen E. Vanderzalm, and William M. Skeens, all of Huntington, and Shawn W. Coffman of Salt Rock;

Kanawha: Joseph P. Assaley, C. Steven Batiste, C. Stephen Edwards, James C. McCabe, Yaacov R. Pushkin, Suzanne I. Starkey, Gary R. Youmans and Jeanne M. Zekan, all of Charleston; Charles Bukovinsky of Dunbar; and Sandra Y. Elliott and Paul T. Kuryla, both of St. Albans;

Harrison: Randall F. Hawkins of Bridgeport; *Jefferson*: Thomas S. Wilson of Charles Town; *Marion*: Kevin M. Clarke and Danny M. Phillips, both of Fairmont; *Mason*: Martha N. Boonsue of Point Pleasant; *Mercer*: Ignacio Cardenas of Princeton; *Monongalia*: Imelda D. Stevenson of Morgantown; *Nicholas*: Melody A. Eiseman of Nettie; *Raleigh*: James A. Barnes, Jr., of Beckley;

Upshur: Darin K. Bowers of Buckhannon; *Wayne*: J. Michael Cassidy of Kenova, James F. Spears II of Fort Gay and Sheryl L. Stephens of Ceredo; *Wood*: Todd A. Broome and Yale D. Conley, both of Vienna; *Wyoming*: Charles A. Garretson of Mullens; *Belmont (Ohio)*: Mark E. Coggins of Shadyside, and *Lawrence (Ohio)*: Linda J. Hathaway of South Point; *Floyd (Kentucky)*: Rondal E. Goble of Prestonsburg, and *Tazewell (Virginia)*: Donald W. Asbury of Bluefield.

Hal Wanger Family Practice Program November 3-5

A variety of some 15 medical subjects will be discussed during the ninth annual Hal Wanger Family Conference November 3-5 in Morgantown.

The meeting site will be the West Virginia University Medical Center Auditorium, with WVU faculty members presenting the scientific program.

Sponsors are the WVU Department of Family Practice, WVU Office of Continuing Medical Education, and the West Virginia Chapter of the American Academy of Family Physicians.

Discussion topics will include:

Doppler techniques in diagnosing congenital heart disease; diagnostic virology and immune incompetence; lupus; urologic problems in children; coronary bypass surgery; stress incontinence; pacemakers; hearing loss in children;

Adult-onset muscle weakness; avoiding practice faux pas; exercise in osteoporosis; diagnosing seizure disorders; diagnostic radiology; plasmophoresis in rheumatoid arthritis; and head and neck injuries in sports.

Also scheduled are lectures and demonstrations on the use of personal computer systems for maintenance of data and records in a physician's practice; and a hands-on ENT "practicum" to acquaint primary care physicians in the use of direct and indirect laryngoscopy, nasal packing for epistaxis, tympanometry, and audiometry.

The conference meets the criteria for 17 hours of credit in Category 1 of the Physician's Recognition Award of the American Medical Association; is acceptable for 17 hours by the American Academy of Family Physicians; and is approved for 1.7 WVU continuing education units.

Continuing Education Activities

Here are the continuing medical education activities listed primarily by the West Virginia University School of Medicine for part of 1983, as compiled by Dr. Robert L. Smith, Assistant Dean for Continuing Education, and J. Zeb Wright, Ph. D., Coordinator, Continuing Education, Department of Community Medicine, Charleston Division. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of The Journal.)

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the Morgantown, Charleston and Wheeling campuses. Further information about these may be obtained from: Division of Continuing Education, WVU Medical Center, 3110 MacCorkle Avenue, S. E., Charleston 25304; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 2000 Eoff Street, Wheeling 26003.

Sept. 3, Morgantown, Treatment Options in Arthritis*

Sept. 9-10, Morgantown, Ob/Gyn Teaching Days*

Sept. 14, Charleston, Advances in Hypertension

Sept. 16-17, Charleston, Advanced Trauma Life Support Course

Oct. 1, Morgantown, Issues in Geriatric Medicine*

Oct. 5, Charleston, Gastroenterology Update

Oct. 14, Morgantown, Ophthalmology Conference

Oct. 15, Morgantown, Common Problems in Nephrology*

Oct. 28-29, Morgantown, Fourth Diagnostic Ultrasound Conference

Nov. 3-5, Morgantown, Ninth Annual Hal Wanger Family Practice Conference*

Nov. 11-12, Morgantown, Fourth Sports Medicine Symposium*

Nov. 14, Charleston, Medicine and Ministry in Cooperative Patient Care

**Held in conjunction with WVU home football game.*

Regularly Scheduled Continuing Education Outreach Programs from WVU Medical Center/ Charleston Division

Buckhannon, St. Joseph's Hospital, first-floor cafeteria, 3rd Thursday, 7-9 P. M. — Sept. 15, "Update on Oncological Chemotherapy," Steven Jubelirer, M. D.

Cabin Creek, Cabin Creek Medical Center, Dawes, 2nd Wednesday, 8-10 A. M. — Sept. 14, "Emergency Evaluation and Management of Acute Dyspnea," Patricia Treharene, M. D.

Oct. 12, "Lower Gastrointestinal Bleeding," Warren Point, M. D.

Gassaway, Braxton Co. Memorial Hospital, 1st Wednesday, 7-9 P. M. — Sept. 7, "Pediatric Update," Ellen Szego, M. D., and Susan Watkins, BSN.

Oct. 5, "Physical Therapy," Louise Christensen, PRT.

Nov. 2, "Update on Nuclear Medicine," Steven Artz, M. D.

Madison, 2nd floor, Lick Creek Social Services Bldg., 2nd Tuesday, 7-9 P. M. — Sept. 13, "Stress-Related Gastrointestinal Disorders," Warren Point, M. D.

Oak Hill, Oak Hill High School (Oyler Exit, N 19) 4th Tuesday, 7-9 P. M. — Sept. 27, "Managing High-Risk Pregnancies," Luis Sanchez-Ramos, M. D.

Welch, Stevens Clinic Hospital, 3rd Wednesday, 12 Noon-2 P. M. — Sept. 21, "Non-Diabetic Endocrine Emergencies," Richard Kleinmann, M. D.

Whitesville, Raleigh-Boone Medical Center, 4th Wednesday, 11 A. M.-1 P. M. — Sept. 28, "Stress-Related Illnesses," Jim Peden, M. D.

Williamson, Appalachian Power Auditorium, 1st Thursday, 6:30-8:30 P. M. — Sept. 1, "Therapeutic Drug Monitoring" (speaker to be announced).

Oct. 6, "Appropriate Use of Antibiotics," Richard Parker, M. D.

AMA Appoints WVU Student

West Virginia University medical student David J. Brailer of Morgantown has been appointed to the American Medical Association's Council on Long Range Planning and Development. Student representatives to various AMA bodies were appointed during the June meeting of the Board of Trustees.

Hypertension Program Planned September 14, Charleston

"Advances in Hypertension," a one-day CME program of papers, panel discussions, workshops and exhibits, will be held on September 14 in Charleston.

The site will be the West Virginia University Medical Center Education Building Auditorium.

The program is designed for physicians, pharmacists, nurses, and health care providers involved in the care of the hypertensive patient.

Registration is requested by September 7.

Lee A. Hebert, M. D.

The morning session will begin with a paper on "Pathophysiology and Complications of the Disease States," by Charles Swartz, M. D., Professor of Medicine and Director, Division of Nephrology and Hypertension, Hahnemann Medical College, Philadelphia.

Following will be a panel on "Workup and Management Strategies of the Hypertensive Patient," including presentations on: "The Mild and Moderate Hypertensive Patient," Mary Lou Lewis, M. D., Clinical Professor of Medicine, WVU Charleston Division, and Senior Nephrologist, Charleston Renal Group; "The Severe and Malignant Hyptertensive Patient," Alan B. Schwartz, M. D., Professor of Medicine, Director of Nephrology Service, and Director of Center of Aging, Hahnemann Medical College; and "The Rational Workup of the Hypertensive Patient," Derrick L. Latos, M. D., The Wheeling Clinic.

Concurrent Workshops

Concurrent workshop sessions at 1 P. M. will be "Non-Drug Therapy and Psychosocial Implications of Hypertension," Lee A. Hebert, M. D., Professor of Medicine and Director, Division of Renal Disease, The Ohio State University; "Treatment of the Pregnant Hypertensive Patient," Gabriel G. Szego, M. D., Charleston Renal Group and Clinical Assistant Professor of Medicine, WVU Charleston Division; and "The Role of the Nurse and the Pharmacist in the Management of Hypertension," Jan Chapin, R.N., Assistant Director, Primary Care Coordinator, Statewide Hypertension Program, West Virginia Department of Health; and Mary Beth Gross, Pharm. D., Assistant Professor of Clinical Pharmacy, WVU Charleston Division.

Concurrent workshop sessions at 2 P. M. will be "Nutritional Aspects of Hypertension," Beverly P. Mann, R.D., Clinical Dietitian, Charleston Renal Group; "Treatment of Essential Hypertension in the Pediatric Patient," Colette Gushurst, M. D., Assistant Professor of Pediatrics, Marshall University School of Medicine; and "Hypertensive Treatment in the Renal Patient," Doctor Swartz.

Paper, Summary to Close Program

Closing out the program will be a paper on "Advances in Hypertension" by Doctor Schwartz and a summary by Frederick C. Whittier, M. D., WVU Professor of Medicine and Chief, Nephrology Section, Morgantown.

The registration fee for physicians will be $38.

Sponsors are the Charleston Area Medical Center, WVU Charleston Division, Charleston Renal Group, West Virginia Department of Health, and WVU School of Pharmacy.

Doctor Lewis is Program Chairman.

For additional registration and other information, telephone the WVU Charleston Division Office of Continuing Education at (304) 347-1249.

A free public session will be held by the sponsors on Tuesday evening, September 13, at the same site. Doctor Hebert will be the featured speaker, and there also will be exhibits, a poster session and free blood pressure screening.

Group Management Meeting September 23-25

The West Virginia Group Management Association will meet September 23-25 at the Charleston Marriott Hotel.

Robert C. Bohlmann, Administrator for the Arlington (Texas) Medical Association, will be the featured speaker on "Group Practice Marketing/Public Relations" and "Physician Income Distribution Alternatives."

A representative of the State Medical Association also will be present.

Other topics to be covered will be "Developing Long Range Plans," "DRG Impact on Physicians," and "Healthcare Competition."

For more information, contact Chet Marshall at 1-800-642-9706.

Health Care Coverage Urged For Jobless

The State and American Medical Associations have renewed their requests to physicians to help the jobless with their health problems. They have proposed a letter to be utilized by doctors, with modifications to fit different office styles, for distribution to patients.

The new effort follows several others, including one by Harry Shannon, M. D., of Parkersburg, the State Medical Association's 1982-83 President, in the March issue of *The Journal.*

"The generosity of our physicians who are sharing the burden of the economic times with their patients is praiseworthy and appreciated," Doctor Shannon wrote in his President's Page message. He added:

"I would urge you to consider, where appropriate, extending and enlarging this generosity, to insure that those who need quality medical care are not hampered in their efforts to achieve it by the fear of inability to pay."

Here is the sample letter now being suggested for physicians' patients, and designed to make them aware of doctors' desires to respond to economic hardships faced by the unemployed or needy:

Dear Patient:

At a time when substantial unemployment, along with reductions in Medicaid and disability programs, continue to make it difficult for increasing numbers of people to obtain necessary health care, I want to assure my patients that such circumstances will not be a barrier to my provision of necessary medical services.

I believe it is important that you continue to receive the medical care you need. Provision of the best medical care possible is, as always, my primary goal in serving my patients.

If you would have difficulty in paying my bills because of unemployment and a loss of health insurance or due to a cutback in Medicaid or disability program, please let me or my staff know. We can make arrangements to provide for necessary care on a fee-reduced basis, or make other financial arrangements.

Most important, do not hesitate to seek my services because you are having financial problems beyond your control. Please let me or my office staff know if you would like to discuss my policy on this further.

Sincerely,

. . . . . , *M.D.*

Doctors Join Staff of WVU's Charleston Division

Four physicians recently joined the staff of the West Virginia University Medical Center/ Charleston Division: Yvette Ysaura Longoria, Instructor of Surgery; Kathleen Vincent Previll, Assistant Professor, Pediatrics; Luis Sanchez-Ramos, Assistant Professor, Obstetrics and Gynecology; and Beverly Dee Spaulding, Assistant Professor, Family Practice.

Doctor Longoria, a native of Elsa, Texas, received her M. D. degree from the University of Monterrey, Mexico. She completed an internship in surgery at the Regina (Saskatchewan) General Hospital in Canada, and a five-year surgery residency at Charleston Area Medical Center.

Doctor Previll received A.B. and M.D. degrees from West Virginia University. Although a native of Wildwood, New Jersey, she attended public school in Wellsburg, West Virginia. She completed pediatric residencies at the Akron (Ohio) Children's Hospital and the Children's

Review A Book

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication.

General Ophthalmology, 10th Edition, by Daniel Vaughan, M. D.; and Taylor Asbury, M. D. 407 pages. Price $17. Lange Medical Publications, Los Altos, California 94022. 1983.

Review of Medical Physiology, 11th Edition, by William F. Ganong, M. D. 643 pages. Price $20. Lange Medical Publications, Los Altos, California 94022. 1983.

Handbook of Pediatrics, 14th Edition, by Henry K. Silver, M. D.; C. Henry Kempe, M. D.; and Henry B. Bruyn, M. D. 883 pages. Price $13. Lange Medical Publications, Los Altos, California 94022. 1983.

Handbook of Poisoning, 11th Edition, by Robert H. Dreisbach, M. D. 632 pages. Price $11. Lange Medical Publications, Los Altos, California 94022. 1983.

memorial Hospital in Oklahoma City. Between residencies, she served as a General Medical Officer with the U. S. Army at Fort Benning, Georgia.

Oklahoma Fellowships

At the University of Oklahoma's Health Sciences Center she completed fellowships in ambulatory pediatrics.

After a year of private practice at the Oberlin (Ohio) Clinic, she was a rural pediatrician with the West Virginia State Health Department.

Immediately prior to her faculty appointment, Doctor Previll was Coordinator of the Pediatric Clinic at CAMC's Memorial Division.

Doctor Sanchez-Ramos was born in Caracas, Venezuela, and attended high school in Miami, Florida. Upon graduation from the University of Madrid, Spain, he received M.D. degrees from Dominican Republic's Universidad Autonoma Santo Domingo and Venezuela's Universidad del Zulia in Maracaibo.

After an internship at the Baptist Memorial Hospital in Jacksonville, Florida, he completed a residency in obstetrics and gynecology at the Medical College of Georgia, and fellowships in genetics and maternal-fetal medicine at the University of Miami.

High-Risk Pregnancies

As a board-eligible specialist in maternal-fetal medicine, he will provide care and consultation for patients with high-risk pregnancies.

Doctor Spaulding, a native of San Antonio, Texas, received her M. D. degree from Mexico's University of Monterrey, and completed a family practice residency at the Family Practice Center, Thomas Memorial Hospital.

In addition to her appointment to the Department of Family Practice, Doctor Spaulding also will serve as Assistant Director of the Kanawha Valley Family Practice Residency Program.

Golden Mountaineer Club Now Three Years Old

West Virginia's Golden Mountaineer Discount Program for those age 60 and older now is itself three years old. It is administered by the West Virginia Commission on Aging, assisted by an advisory committee of businessmen and community leaders.

Participation by those in the business community of course is voluntary. The Commission on Aging has advised that those desiring more information should contact Mr. Michael Marlowe, Director, Golden Mountaineer Club, Building 1, Room B-41, State Capitol, Charleston 25305.

Hospital Staff Reps Meet First Time With AMA

When the American Medical Association House of Delegates met in Chicago in June, the 351 delegates seated included 281 representing state medical associations; 61 representing national medical specialty societies, and 9 section and service delegates representing hospital medical staffs, medical students, medical schools, resident physicians, Army, Navy, Air Force, USPHS, and the Veterans Administration. The House considered 147 resolutions and 74 reports.

The American Hospital Association and the American Dental Association sent official observers. At this meeting the House voted to invite also the American Osteopathic Association, American Group Practice Association and the National Medical Association to send official observers.

Nearly 700 representatives of hospital medical staffs met for the first time in conjunction with the AMA House, and section officers were elected, including an AMA delegate. The section introduced eight resolutions. With 7,000 U. S. hospitals eligible to send representatives, attendance is expected to grow. The section will meet again at the Interim Meeting in Los Angeles, and *all hospitals are urged to send representatives.* The section will meet December 2-4, and the AMA House meets December 4-7.

JACH Manual Changes

After extensive debate on the Medical Staff Section of the JCAH *Accreditation Manual for Hospitals,* the House affirmed the following principles as the basis for any revisions in the JCAH Manual:

—Continue the use of the term "medical staff" in the title of the chapter and throughout the manual.

—Delete any specific references to limited licensed practitioners now contained in the medical staff chapter of the 1983 *Accreditation Manual for Hospitals.* This does not preclude such practitioners from having hospital privileges consonant with their training, experience, and current competence if approved by the normal credentializing process.

—Provide consideration of qualified limited licensed practitioners in accordance with state law and when approved by the executive committee of the medical staff and by the governing board and, when their services are appropriate to the goals and mis-

sions of that hospital, taking into account the training, experience, and current clinical competence of the practitioners.

—Provide that the executive committee of the medical staff be composed of members selected by the medical staff, or appointed in accordance with the hospital bylaws. All members of the active medical staff, as defined in the medical staff bylaws, are eligible for membership on the executive committee, and a majority of the executive committee members must be fully licensed physician members (doctors of medicine or doctors of osteopathy) of the active medical staff in the hospital.

—Assure that the medical care of all patients remains under the supervision and direction of qualified, fully licensed physicians (doctors of medicine or doctors of osteopathy).

—Assure that the continued high quality of care, credentializing of physicians and other licensed practitioners, and effective quality assurance programs remain under the supervision and direction of fully licensed physicians.

Indemnity Versus UCR

Another issue that generated lengthy discussion was a report presenting an analysis of payment mechanisms utilized by third-party payors for reimbursement of physicians' services.

The Council on Medical Service presented a comprehensive discussion of *indemnity versus UCR reimbursement*, and asked the delegates to consider the matter and discuss it with their constituents over the next six months in preparation for discussion and possible action at the 1983 interim meeting in Los Angeles.

Under an indemnity system, a third party pays a physician a set amount for a covered service, with the physician free to charge his own fee and collect any charge in excess of the level at which the third party decides to pay.

The Council believes that if third parties change to an indemnity system of payment, patients would be benefitted by:

—Insuring their continued access to care not through external regulation of fees but through market forces.

—Increasing both physicians' and patients' sensitivity to costs and quality of care provided.

—Allowing them continued freedom of choice rather than being increasingly restricted to "participating" providers as a condition of coverage.

—Facilitating understanding and comparison of insurance coverages.

The report said that rate determination for third parties would be simpler. For physicians, the Council believes that the indemnity approach could bring improved patient/physician interaction by eliminating false expectations of the amount of the third-party payment. This approach, the report added, also will provide physicians the freedom to charge what they believe to be a fair and equitable fee, subject only to normal and effective market constraints.

88 Members In New WVU Class Announced

Sixty-three men and 25 women entered their first year in the West Virginia University School of Medicine when classes began August 22.

The new class, which includes 84 West Virginians, three Pennsylvanians and one New Yorker, completed undergraduate work at 39 different colleges or universities. More than half, or 53, received their premedical education in West Virginia, with WVU accounting for 36.

Five attended Wheeling College, and three are graduates of West Virginia Wesleyan. Marshall University has two graduates as do Shepherd and Alderson-Broaddus colleges. Bethany College, West Virginia Institute of Technology and Concord College are represented by one graduate each.

The remaining 35 attended 30 different out-of-state colleges or universities.

The West Virginians come from 23 counties. Thirty-two class members list home addresses in Monongalia County. This reflects in some cases the change of legal address made by students during their undergraduate days at WVU.

Ten members of the class list home addresses in Ohio County. Eight are from Kanawha County and six are from Cabell.

Applications were mailed to 247 West Virginians and 189 non-residents. Interviews were granted to 239 state and 53 out-of-state applicants.

Grade point average for the applicants accepted as of April 27 was 3.44 with a science average of 3.57.

Names listed represent those accepted into the class as of July 1, with the exception of one class member who requested that his name not be released for publication. The listing does not

include the names of alternates who may be admitted if withdrawals occur.

Members of the class include:

Berkeley: Hedgesville — Allen M. Lewis; *Brooke*: Weirton—Robert Starr; *Cabell*: Huntington—Allen B. Joseph, Susanne E. Fix, Glenn C. Robinson, Mariel M. Smith, and David M. Vaziri; Milton—Michael J. Sullivan; *Fayette*: Fayetteville—John L. Stanley; *Hancock*: Weirton—Robert D'Angelo, Stephen Holbrook, Gina M. Rasicci, and Ronald S. Wargacki;

Hardy: Mathias—Crystl L. Dove; *Harrison*: Bridgeport — Toni B. Goodykoontz; *Jefferson*: Charles Town—Thomas S. Wilson; Shepherdstown—Charles B. Hicock; *Kanawha*: Charleston—William P. Cheshire, Jr., Lisa A. Copenhaver, John P. Hayes, Robert B. Jackson, Beth D. Kagen, Carol A. Proops, and John J. Schaefer; Pinch—Dayton D. Payne;

Marion: Fairmont—Bruce E. Mazurek and Gregory A. Thompson; *Mason*: Point Pleasant — Elizabeth R. Boonsue; *Mercer*: Bluefield — Daniel L. Sadler; Flat Top—Glen A. Marino; *Mingo*: Delbarton—John L. Goad;

Monongalia: Morgantown — Andrew K. Bean, Kathleen H. Blackburn, James F. Cahill, Felicia K. Cain, Jyotsna N. Dalal, Bruce J. Davidson, Richard J. DeAngelis, Jaimela J. Dulaney, Mark S. Franczak, William C. Hamilton, Katherine Hwu, Evan A. Jones, Bruce P. Klein, Jay J. Libys, Matthew L. Miller, Jack C. Moore, John P. Muse, Susan E. Palmer, David J. Rodak, Judith T. Romano, James H. Sherry, Donald R. Shoenthal, Jr., Timothy K. Simmons, Edward E. Stewart, Jr., Michael Thomas, Mark O. Thornton, Devin J. Troyer, George J. Ullrich, Anthony J. Viti, Russell I. Voltin, Bruce D. Weinstein, and Wynne E. Woodyear;

Morgan: Berkeley Springs — Douglas H. Howerton; *Ohio*: Wheeling—Deniz F. Bastug, Kathleen P. Bors, John P. Dagirmanjian, Edward D. DeVelin, Helen M. Kellett, William H. McCuskey, James E. McDermott III, Nicholas D. Poulos, Randall A. Swain, and Todd A. Witsberger; *Preston*: Kingwood—Daniel B. Thistlethwaite; Terra Alta—Susan M. Sypolt;

Putnam: Hurricane — Sabrina D. Craigo; *Raleigh*: Daniels — Mark Warvariv; *Ritchie*: Harrisville—Debra S. Hinzman; *Summers*: Elton —Deborah Schmidt; Hinton—Lisa S. Persinger; *Wood*: Parkersburg — Michael A. Russell; Vienna—Mark T. Darnell;

Out-of-State: New York, Flushing—Marilyn Radke; Pennsylvania, Allison Park — John T. Cinicola; Brownsville—John J. Duda, Jr.; Pittsburgh—Gary R. Bergman.

Surgery, Educational Skills Programs Set By MU

Countinuing medical education programs on surgery and educational skills are among those currently being announced by Marshall University School of Medicine.

William A. Altemeier, M. D., a national authority on surgical infections, leads the list of guest faculty for Marshall's fourth annual Surgical Symposium on September 24 in Memorial Student Center.

The program will include talks on Staph. aureus infections, gram negative infections, peritonitis, and intra-abdominal abscess, according to Charles W. Jones, Ph.D., CME Director. Other topics include "Tissue Gas, Death, Life" and "Infection Complications in the Impaired Host." Workshops on hepatitis, genito-urinary infections and antibiotic use also will be offered.

In addition to Doctor Altemeier, who is the Christian R. Holmes Professor Emeritus of Surgery at the University of Cincinnati, the guest faculty includes Donald E. Fry, M. D., Chief of Surgery at the Cleveland Veterans Administration Hospital; Westley Furste, M. D., Clinical Professor of Surgery at Ohio State University and Chairman of Surgery at Mt. Carmel Medical Center, and Robert L. Yarrish, M. D., Assistant Professor of Medicine in the Division of Infectious Diseases at the University of Kentucky Medical Center.

Six MU physicians also will serve on the symposium's faculty.

CME Credit, Fees

The program has been approved for continuing medical education credit by the American Medical Association, the American Academy of Family Physicians, and MU.

The fee is $65 for physicians and $10 for resident physicians and medical students.

The School of Medicine will offer its volunteer and full-time faculty a special program on educational skills October 20-22, according to Dr. David K. Heydinger, Associate Dean for Academic Affairs. About 250 community physicians serve on MU's volunteer faculty.

The conference will address topics such as effective audiovisual use, lecturing, and teaching one-on-one in the classroom, in the office and on hospital rounds. It also will include sessions on preparing for the preceptorship experience, reducing stress in the office and evaluating students.

(continued on next page)

Guest Faculty

Guest faculty for the event will include Glen Geelhoed, M. D., Associate Professor of Surgery at George Washington University Medical Center; James Young, Ph.D., Vice Chancellor for Health Affairs, West Virginia Board of Regents; John-Henry Pfifferling, Ph.D., Director of the Center for the Well-Being of Health Professionals, and Xenia Tonesk, Ph.D., Director of the Clinical Evaluation Project, Association of American Medical Colleges.

For more information on either conference, contact Doctor Jones at (304) 52-0515.

Cleveland Clinic Physician Addresses Urologists

Dr. Ralph A. Straffon, Chairman of the Department of Urology at the Cleveland Clinic, was a principal speaker for the recent spring meeting of the West Virginia Urological Society at the Greenbrier in White Sulphur Springs.

This was reported by Dr. Tara C. Sharma of Huntington, the Society's Treasurer, who commented, "We encourage all of the urologists in the state to attend in greater numbers and not miss out on the good lectures and mutual discussions on problems peculiar to our region."

Doctor Straffon gave lectures on adrenal surgery, adrenal physiology, and disease of the adrenal, Doctor Sharma said. He added that there were other papers on the evaluation and treatment of renal and adrenal masses, and an x-ray session in the afternoon of the one-day meeting.

The meeting was held in conjunction with that of the West Virginia Chapter, American College of Surgeons.

Gastroenterology CME Program To Include Duke Doctors

Two faculty members from the Duke University School of Medicine will speak during an afternoon program, "Gastroenterology Up-date," on October 5 in Charleston.

The two Duke physicians will be Drs. John T. Garbutt, Jr., Associate Professor of Medicine, Gastroenterology Division, who will talk on peptic ulcer disease, and Paul Killenberg, Associate Professor of Medicine and Chief, Liver Service, who will discuss chronic hepatitis.

The CME offering, sponsored by Charleston Area Medical Center and West Virginia University Medical Center, Charleston Division, will begin at 1 P. M. following registration starting at noon. The site will be the WVU Medical Center Education Building Auditorium.

Also on the program will be talks by Drs. Brittain McJunkin, Clinical Assistant Professor of Medicine, WVU Charleston Division, on esophageal motor disorders; and Duane D. Webb, Associate Professor of Medicine, Marshall University School of Medicine, on colonic polyps.

William O. McMillan, Jr., Charleston gastroenterologist, will be the moderator.

Adjournment will be at 5 P. M.

State Financial Woes Hit Medical Services Area

State Government's financial woes apparently mean new problems for the Medicaid Program, and at least some inconvenience for physicians and others providing services to recipients.

The Department of Human Services, which administers the medical services program and funds, has explained that the agency is receiving only one-twelfth of its state appropriation on a monthly basis.

This makes it difficult to pick up carry-over bills the agency has from the past fiscal year and meet current liabilities. In fact, an agency spokesman has estimated that the catch-up process will continue through September.

The money problem, and the monthly allotment pattern, have as a background a recent order by Governor Rockefeller directing a new three-per cent spending cut for state agencies for the current fiscal year.

Vascular Surgery Conference Planned For Snowshoe

Physicians from Vanderbilt University, Ohio State University and the University of Pittsburgh will be included on the faculty for the Second Annual Snowhoe Vascular Surgery Conference to be held next February 19-22.

The program, which will deal with current topics in vascular surgery, will be held at the Snowshoe ski resort under the sponsorship of the Office of Continuing Medical Education, West Virginia University School of Medicine, Morgantown, and the WVU Department of Surgery.

Registration information can be obtained from the CME office at 104 Basic Science Building, WVU Medical Center, P. O. Box 6302, Morgantown 26506-6302. Telephone (304) 293-3937.

Public Entitled To Amounts Medicaid Pays Doctors

Kanawha County Circuit Judge John Hey has ruled, in a case brought by the West Virginia State Medical Association, that amounts paid physicians under the state's Medicaid Program are public information and may be released to the press and others.

The Medical Association, in the first case of its kind related to West Virginia's 1977 Freedom of Information Act, brought an injunctive and declaratory judgment action against Human Services Commissioner Leon Ginsberg to prevent public release of such personalized information.

Because of some questions it saw in the public interest and privacy area, the Association's effort was primarily directed toward obtaining a judicial determination of the scope of the 1977 act, and what information could be considered releasable.

Judge Hey observed that whether a physician participates in the Medicaid Program is a matter of personal decision, and held that amounts paid are public information.

Pending a hearing on August 15, Judge Hey granted a temporary injunction August 3. After his ruling, also on August 15, he continued the injunction in effect for 10 days to permit a decision by the Association as to whether it might desire to appeal to the West Virginia Supreme Court of Appeals.

There was no appeal.

Prescription Drug Abuse Attack Launched

Prescription drug abuse recently came under attack as the Florida Medical Association, Massachusetts Medical Society and Michigan Medical Society endorsed field tests of the American Medical Association model for identifying "script doctors." Several other medical societies are gearing up to help pinpoint the sources of drug diversion in their states. Participating medical societies will work with existing state and federal drug enforcement agencies as well as educate physician members about the ruses that addicts and others employ to obtain drugs.

Current federal data show that prescribable drugs are involved in almost 60 per cent of all drug-related emergency room visits and 70 per cent of all drug-related deaths.

Medical Meetings

Sept. 7-10—Peripheral Vascular Disease Symposium (Saint Anthony Hospital), Columbus, OH.

Sept. 23-25 — W. Va. Group Management Assoc., Charleston.

Sept. 24—MU Surgical Symposium, Huntington.

Sept. 29-Oct. 1—Am. Assoc. for the Surgery of Trauma.

Sept. 29-Oct. 2—Am. Society of Internal Medicine, San Francisco.

Sept. 30-Oct. 1 — W. Va. Chapter, Am. College of Surgeons, Morgantown.

Oct. 2-5—Am. Neurological Assoc., New Orleans.

Oct. 5-8—Am. Thyroid Assoc., New Orleans.

Oct. 7-8—AMA Congress on Occupational Health, Beachwood, OH.

Oct. 16-21—Am. College of Surgeons, Atlanta.

Oct. 20-22 — Educational Skills (MU Medical School), Huntington.

Oct. 22-27—Am. Academy of Pediatrics, San Francisco.

Oct. 23-26—Am. College of Gastroenterology, Los Angeles.

Oct. 23-27—Am. College of Chest Physicians, Chicago.

Oct. 24-27—Am. College of Emergency Physicians, Atlanta.

Oct. 26-30—Am. Academy of Child Psychiatry, San Francisco.

Oct. 30-Nov. 3 — Am. Academy of Ophthalmology, Chicago.

Nov. 6-9—Scientific Assembly, Southern Medical Assoc., Baltimore.

Nov. 7-9—Am. Medical Women's Assoc., Dearborn, MI.

Dec. 4-7 — Interim Meeting, AMA House, Los Angeles.

1984

Jan. 27-29—17th Mid-Winter Clinical Conference, Charleston.

Feb. 9-14—Am. Academy of Orthopaedic Surgeons, Atlanta.

Feb. 12-15—W. Va. Perinatal Assoc., Snowshoe.

March 17—Annual Meeting, W. Va. Affiliate, American Diabetes Assoc., Wheeling.

May 2-5—W. Va. Chapter, Am. College of Surgeons; and W. Va. Otolaryngological Society, White Sulphur Springs.

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WVU Medical Center
–News–

Compiled from material furnished by the Medical Center News Service, Morgantown, W. Va.

More State Heart Surgery Said Available

Heart surgery is entering a new era, and WVU Medical Center has expanded its program to meet the resulting challenges.

In recent years coronary artery bypass has become one of the most common major operations, performed last year on about 200,000 persons in the United States.

Dr. John C. Alexander, Jr., is the new Chief of Cardiothoracic Surgery at University Hospital and Associate Professor of Surgery. Since last September he has performed more than 150 "pump" operations, referring to the equipment which takes over heart and lung functions during the surgery.

Doctor Alexander's goal for the Medical Center is about 450 such operations a year, nearly 80 per cent of which would involve coronary artery bypass. Repair of heart valves and congenital defects account for the rest.

"Based on national statistics, West Virginia has probably 1,000 persons per year who need bypass surgery, and too many of these persons go outside the state to have it done," he said.

The operation is available in West Virginia in Charleston, Huntington and Morgantown, and Doctor Alexander believes the WVU Medical Center is well equipped to handle up to 500 cases, especially when a new cardiac care unit is completed.

Neurosurgery Post Filled By Doctor Kaufman

Howard H. Kaufman, M.D., a former faculty member at the University of Texas Medical School at Houston, has been named Professor and Chairman of Neurosurgery.

Doctor Kaufman, a graduate of Yale University, received his medical degree from the Columbia University College of Physicians and Surgeons.

Following an internship in surgery at the University of Minnesota Hospital, he was a Fellow at the National Hospital for Nervous Diseases in London, England, and a Clinical Associate in Surgical Neurology at the National Institute of Health. He completed his residency training at Columbia Presbyterian Medical Center's Neurological Institute of New York.

Author of 46 published journal articles, five abstracts and seven book chapters, he has contributed widely to the professional literature on such subjects as brain death criteria, carotid artery disease, hydrocephalus in infants, computerized tomography, and metabolic and nutritional problems in patients with head injuries.

LaRosa Family Establishes Cancer, Heart Fund

A $100,000 endowment fund for cancer and heart research has been established for WVU's Department of Surgery by the family of the late James and Emily LaRosa of Clarksburg.

LaRosa, founder of the LaRosa Fuel Company, a diversified coal mining firm, died in May at the age of 91. He and his wife, who died two years earlier, had been patients at the WVU Medical Center and had long been patrons of the WVU School of Medicine.

Dr. Alvin L. Watne, Professor and Chairman of Surgery, noted that earlier this year the LaRosa family also funded construction of a heliport adjacent to the WVU Hospital emergency department.

Cancer Society President

The new President of the West Virginia Division of the American Cancer Society is Alvin L. Watne, M. D., Chairman of the Department of Surgery.

Installed at the Division's recent annual meeting at Canaan Valley Lodge, Doctor Watne has been involved in cancer research, teaching and service since he began his medical career in the mid-1950s. He is Chairman of the State Medical Association's Cancer Committee.

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Third-Party News, Views and Program Concerns

Association Cites Exception In Medical Records Law

Inquiries have been received by the State Medical Association relative to the interpretation of Enrolled H.B. 1352, W.Va. Code 16-29-1 et. seq. concerning the requirement to furnish patients with copies of records upon request. (See the May issue of *The Journal*, page 112, for the complete text of the Act.)

It is the opinion of the Association counsel and other lawyers to whom the question has been directed that the Act does not apply in cases where an individual is sent to the physician for evaluation by an employer, insurance company or governmental agency, i.e., Workers' Compensation, Social Security, etc. Such evaluations are for the purposes of the agency which has contracted with the physician. A patient-physician relationship has not been established; therefore the Act is inapplicable.

Individuals who make requests for copies of evaluations should be directed to the sending agency. These agencies are under various legal mandates to furnish copies of such evaluations to the individual or his representative, usually at no cost.

Senate Panel Wants Doctors To Finance Health Plan

If the Senate Finance Committee has its way, a health plan for the unemployed will be financed by physicians and Medicare beneficiaries.

The committee voted 10 to 2 recently to pay for a health plan for the unemployed by increasing Medicare Part B premiums and by freezing the maximum amounts Medicare will pay physicians for a particular service. The panel then sent the measure, which provides $1.8 billion in block grants to states, to the Senate floor.

Senate Democrats plan an all-out war on the Finance Committee measure and have vowed that no plan tying health insurance for the unemployed (HIU) to Medicare cuts will "emerge from the Senate." Senator Edward Kennedy (D-MA) is threatening a filibuster against the measure.

House Agreement Unlikely

Even if the Senate were to pass the measure, the HIU version enacted by the House of Representatives in early August does not include a financing mechanism. House agreement to the Finance Committee plan has been considered unlikely. The Senate was not expected to vote on HIU until after the Congress' summer recess.

The Finance Committee HIU bill would limit Medicare reimbursement to physicians by reverting to the prevailing charge limits in effect for the program prior to the annual update that took place July 1, 1983. They would be held at that level from October 1 until July 1, 1984. Because the measure would limit only prevailing fees, it is less restrictive than the Reagan Administration proposal to limit both prevailing and customary fees. Physician reimbursement savings in the Finance proposal are estimated at $1,375 million over the next three years.

Increase Part B Premiums

Another $359 million in savings would come from increasing Part B premiums each year so that they always would cover 25 per cent of the cost of the medical services reimbursed under that part of Medicare. A temporary provision setting premiums at 25 per cent of program costs is scheduled to end December 31, 1984.

The combined savings from the two proposals would finance a two-year, $1.8 billion health plan for the unemployed. States would be required to put up matching funds and to means test eligibility. Benefits could not be provided to any family with an income greater than the state's median income for similarly sized families. The state could collect up to eight per cent of the jobless worker's unemployment check to help pay for benefits.

Obituaries

HAROLD B. ASHWORTH, M. D.

Dr. Harold B. Ashworth, Glen Dale general practitioner and surgeon, died on July 13 in a hospital there. He was 76.

Doctor Ashworth was known in his area as "Dr. Harold," carried over from the days when both he and his father, the late Dr. Robert Ashworth, were practicing medicine at the same time.

He was a Past Chairman of the West Virginia Board of Health, and Past President (1948) of the Marshall County Medical Society.

A member of the staff of Reynolds Memorial Hospital in Glen Dale, Doctor Ashworth served as a captain in the Army during World War II, receiving a Purple Heart and a Silver Star.

Born in McDowell County, he was graduated from West Virginia University, and received his M. D. degree in 1930 from the Medical College of Virginia.

Survivors include the widow; three daughters, Mrs. William Knight of Tulsa, Oklahoma; Mrs. Edward Murrah of Columbus, Georgia, and Mrs. William Leadbetter of Moundsville; a stepdaughter, Mrs. Robert Knight of Glen Easton (Marshall County); three stepsons, Ronnie High of Mansfield, Ohio, and Roger High and Dr. Philip High, both of Wheeling; three brothers, Robert Ashworth and John Ashworth, both of Beckley, and Charles Ashworth of Delmont, Pennsylvania; and two sisters, Mrs. I. E. Howell of Chesterland, Ohio, and Mrs. Cecil Fulkerson of Charlotte, North Carolina.

* * *

PEDRO L. CASINGAL, M. D.

Dr. Pedro L. Casingal of Charleston, an ophthalmologist, died on July 28 in a hospital there. He was 52.

Doctor Casingal had practiced since 1972 in Charleston and Oak Hill, and formerly was located in Montgomery.

A native of the Philippines, he received his M. D. degree in 1975 from the University of Santo Tomas in Manila. He interned at St. Francis Hospital in Blue Island, Illinois, and completed a residency at Queens and City hospitals in New York City.

Doctor Casingal was a member of the Fayette County Medical Society, West Virginia State Medical Association, American Ophthalmological

(continued on next page)

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*Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME, Philadelphia, Lea & Febiger, 1980, p. 781.

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Society, Society of Philippine College of Surgeons, and International College of Surgeons.

Survivors include the widow; three sons, Paul Casingal, Pedro Casingal, Jr., and Phillip Casingal, all at home; one daughter, Zemonette Casingal, at home; the stepmother, Juanita Casingal of the Philippines; four brothers, Candido Casingal of New Jersey, Dr. Edwardo Casingal of Lake Wales, Florida; Dominador Casingal of Long Island, New York, and Feliciano Casingal, Jr., of the Philippines; four sisters, Theodora DeVera and Victoria Quedado, both of Long Island; Isabel Viray of the Philippines, and Remedois Madrigal of Virginia Beach, Virginia.

* * *

RAYMOND W. CRONLUND, M. D.

Dr. Raymond V. Cronlund, Philippi obstetrician-gynecologist, died on July 26 in a Clarksburg Hospital. He was 71.

Born in Philadelphia, Pennsylvania, Doctor Cronlund was graduated from Gettysburg (Pennsylvania) College, and received his M. D. degree in 1940 from Hahnemann Medical College in Philadelphia. He served his internship and residency at Hahnemann Hospital, and completed additional postgraduate work at the University of Pennsylvania.

Doctor Cronlund practiced one year in Norristown, Pennsylvania, prior to going to Philippi in 1951, at which time he became a staff member of The Myers Clinic Hospital there. With the incorporation of Alderson-Broaddus College and The Myers Clinic, he practiced at Broaddus Hospital in Philippi from 1954 until his recent retirement.

Doctor Cronlund was an honorary member of the Tygart's Valley Medical Society, West Virginia State Medical Association and American Medical Association, and a member of the American Board of Obstetrics and Gynecology, Southern Medical Association, and Central Association of Gynecology.

He was a veteran of World War II.

Survivors include the widow; two daughters, Christine Clayton of Dayton, Ohio, and Eleanor A. Cronlund, at home; one sister, Eleanor S. Cronlund of Sun City, Arizona; two brothers, Ernest Cronlund of Sun City and Martin F. Cronlund of Gettysburg.

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Carbon Dioxide Laser In Otolaryngology: Head And Neck Surgery

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Advances in technology have found their application in medicine and surgery. Einstein's theory on the property of light—that it could be stimulated to a higher energy level—led to the development of the laser. The purpose of this paper is to describe the various surgical applications of the CO_2 laser on 1,000 head and neck cases from 1977 to the present. Its setup, technique and advantages are presented.

THE development of the laser, an acronym for Light Amplification by Stimulated Emission of Radiation, by Shawlaw and Townes, in 1950, heralded a new surgical tool, the "light knife." The persistent need of surgeons to improve techniques for tissue removal has paved the way in exploring the uses of laser sources.

In 1972, Strong and Jako[1] reported the use of the CO_2 laser for removal of papillomas and other benign lesions of the larynx. Since then, the surgical application of the CO_2 laser in the head and neck area has been expanded and reported by other surgeons.[2-9]

The electromagnetic attributes and the tissue effects of the CO_2 laser have been described by Stellar[10] and Mihashi,[11] respectively. The proper surgical application of the CO_2 laser is dependent not only on technical skill but also on the understanding of the nature of the laser light. Thus, these attributes and effects are briefly reviewed.

Carbon dioxide lasers emit energy in the infrared invisible portion of the spectrum at 10.6 U wavelength. It delivers purely heat energy, and has no ionizing effect. For surgical use, the invisible CO_2 laser beam is coaxed with a helium-neon light, and is projected as a 1.5-mm. to 2.0-mm. red dot. Its effect on tissue is entirely thermal, and is completely absorbed by all biologic tissue, regardless of its pigmentation.

The amount of tissue destruction is dependent on the tissue water content. While the heat itself may melt some materials and denature proteins, the major effect of the heat in living tissue is to convert instantly extra- and intracellular water to steam. The steam then expands explosively, separating and destroying the tissue cells (explosive tissue evaporation).

Brief application of laser energy to mucosal epithelium produces crater-shaped wounds. Their size and configuration are related to the intensity of the energy absorbed, i.e., the power and duration. Beyond 500 microns of the wound edge, tissue injury is not apparent. This is in contrast to the trauma of other surgical methods which involve manipulation or unpredictable penetration effects as in electrocautery or cryosurgery. Three weeks after laser application, the wound is completely healed with hardly a scar.

Materials and Methods

The surgical experience with the CO_2 laser started in 1977 and continues through the present. A 50-watt, continuous-wave Coherent 400 carbon dioxide laser machine, coupled with a 400-mm. lens Zeiss microscope, has been used. This was retrofitted with the 450 model a year ago. The optical cavity of the newer model is mounted to the stand of the operating microscope, instead of the microscope head; this al-

lows easier adjustment of the operating microscope.

A total of 1,000 head and neck patients were managed surgically by one surgeon (R.Y.L.) using the carbon dioxide laser at the Eye and Ear Clinic of Charleston, West Virginia. Eighty per cent of these patients had laryngo-tracheal lesions, and 20 per cent of them had lesions of the intraoral cavity and face and neck regions (Table). The youngest patient was one year old; the oldest, 90 years old.

General anesthesia[12] was used 90 per cent of the time. A red rubber endotracheal tube, wrapped with aluminum foil, was used for intubation. An insufflation technique using fluothane (Halothane) through a #16 transnasal catheter was used in selected cases. Exposure of the posterior commissure and arytenoids was accomplished by displacement of the endotracheal tube anteriorly with the tip of the laryngoscope. Lidocaine hydrochloride one-per cent (Xylocaine) was used for local anesthesia and superior laryngeal nerve block while tetracaine hydrochloride two-per cent (Pontocaine) was used for topical anesthesia.

TABLE

Classification of Various Lesions Treated with CO_2 Laser

LARYNGO-TRACHEAL	
Papilloma	Stenosis
Polyp	Cyst
Contact Ulcer	Hemangioma
Keratosis	Laryngocele
Carcinoma	Nodule
Web	Hypertrophic ventricular band
Granuloma	Fibroma
Arytenoid	
INTRAORAL CAVITY	
Carcinoma	Lymphoma
Hemangioma	Ulcer
Leukoplakia	Papilloma
Tonsil	(Marginal Mandibulectomy)
FACE and NECK	
Hemangioma	Carcinoma
Keloid	Scar
Keratosis	Cyst

The Jako and modified Jako laryngoscopes were used for exposure of the larynx and upper cervical trachea while the Dingman and Jennings mouthgags with retractors were used for the intraoral cavity. Positioning of the patients for laryngeal and intraoral laser excisions was achieved by tilting (up or down) the operating table in a Rose position. Sandbags placed on each side of the neck were used to stabilize the head and neck. The patients' eyes[13] were protected by aluminum eye patches, and the adjacent structures of the target areas were protected either by wet neuro pattes or wet 4 x 4 gauze sponges. Protective eyeglasses were worn by the operating room personnel.

The laser beam, prior to its use, was routinely checked for correct alignment of the carbon dioxide laser light with the helium-neon red dot. Commonly, a power setting of 18 watts is combined with a time exposure of one fifth of a second for laryngeal cases, and a 25-watt power with continuous mode for intraoral and face and neck lesions.

Figure 1. Juvenile papillomatosis occluding the larynx in a three-year-old child.

Figure 2. Regression of juvenile papillomatosis after multiple CO_2 laser surgery without stenosis.

Blood vessels larger than 0.5 mm. were controlled either by ligation or electrocoagulation. Constant traction of the tissue to be removed and continuous control of bleeding, mucous secretions and the laser smoke around the operative area were carried out for a more effective laser action. Mucosal defects of the intraoral cavity of less than three cm. were allowed to heal by secondary intention, (i.e., soft palate, buccal and tonsillar areas).

Ninety-eight per cent of the patients were fed orally once they were fully reactive from the anesthetics. The same number of patients were discharged the morning after surgery.

Results

There was no postoperative bleeding, severe edema or severe pain after laser surgery. Healing in all cases was complete in about four weeks with minimal scar formation. One patient who had a squamous cell carcinoma laser-excised, including a margin of the mandible, required a tracheostomy due to subsequent cellulitis of the floor of the mouth and severe laryngeal edema 48 hours after surgery. Anterior laryngeal webs, occupying more than one fourth of the membranous portion of the vocal cords, required endoscopic keel insertion[14] after laser excision; the keel was left for at least three weeks. Laser excision did not prevent the recurrence of juvenile laryngeal papillomatosis, but it did minimize scarring and subsequent stenosis (Figures 1 and 2). The use of the laser for "debulking"[15] obstructive malignant tumors of the larynx and cervical trachea, for endoscopic arytenoidectomy, and extensive procedures of the larynx and intraoral cavity has obviated the use of a tracheostomy.[16] With more experience and operating room teamwork, the surgery time has become much shorter. Hospitalization is now shortened since patients can be discharged without fear of an airway problem due to edema or bleeding.

Discussion

The five-year experience with the carbon dioxide laser has shown that the laser, when properly applied, is an effective tool for the head and neck surgeon because it provides precision, sophistication of excision, and atraumatization of the adjacent normal tissues. The coupling of the carbon dioxide laser with the operating microscope and with the micromanipulator (joy stick) provides not only better visualization and magnification of the target tissues but also precision and facility of operation.

The major contraindication to laser surgery in any area is the inability to visualize fully the entire lesion to be excised in terms of the circumferential and deep borders of the lesion. However, the CO_2 laser can be utilized as a "debulking" tool for malignant tumors prior to chemotherapy or radiation,[16] and also for palliation.

Editor's Note: Here are the generic drugs and trade names (in parentheses) to which reference is made in this manuscript: fluothane (Halothane); lidocaine hydrochloride (Xylocaine); and tetracaine hydrochloride (Pontocaine).

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Sonographic Antepartum Diagnosis Of Dicephalus Dipus Dibrachius: Two Case Reports

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Beckley, West Virginia

Two cases of dicephalus dipus dibrachius diagnosed in early pregnancy by sonography are presented. Obstetrical management is discussed.

CONJOINED twins and/or double monsters are the subject of art: the Florentine twins in bas-relief in the Church of La Scala, poetry in a sonnet of Petrarch, and entertainment in the Barnum circus which featured the famous Bunker Siamese twins, Chang and Eng.[1] It also is a rare and tragic obstetrical event occurring approximately once in every 50,000 births.[2] Because of the rarity, prepartal recognition is unusual. Antepartum diagnosis is important for allowing parental involvement in decision making, for planning optimal termination or delivery approach, for minimizing maternal and fetal mortality and morbidity, and for adequate preparation for neonatal resuscitation, diagnosis and therapy. Recognition is difficult because physicial examination and roentgenographic evaluation are frequently misleading. Ultrasound has proved extremely useful in the diagnosis.

This paper reports two cases of dicephalus dipus dibrachius diagnosed in the antepartum period by ultrasonography.

Case Reports

Case 1, R. R., is a 32-year-old, white, married female, Gravida 9, Para 2, ab 6. She was seen for her first prenatal visit at nine weeks' gestation. Clinical history revealed an initial uncomplicated pregnancy in 1969, followed by five consecutive, documented, first-trimester abortions. A hysterogram performed in 1976 was normal. A second successful uncomplicated pregnancy occurred in 1978. There was no paternal or maternal family history of anomalies. Medications used since her LMP included Zomax, Actifed and Theophylline. On February 1, 1981, the patient had a chest x-ray and nuclear lung scan for symptoms of chest pain.

The initial clinical examination was normal with an intrauterine pregnancy of nine weeks' gestation size.

The prenatal visit at 13 and one half weeks was unremarkable. By 17 weeks' gestation, a size-dates discrepancy was detected by clinical measurements, and the patient was referred for ultrasound evaluation. Initial sonography was performed with a 3.5 MHz* linear array scanner. The technician immediately recognized the abnormality of two heads attached to two spines which gradually fused. Four extremities were identified. A single fetal heart was detected.

A subsequent scan done with a 3.0 MHz** mechanical sector scanner was performed so that findings could be recorded on video tape. Figures 1, 2 and 3 are Polaroids made directly from video tape recordings. Figure 1 shows both heads and the gradually fusing spines, and Figures 2 and 3 show the complex spinal arrangement. The diagnosis was presented to the couple. They viewed the video tape and Polaroids and

* Advanced Diagnostic Research, Inc., Tempe, Arizona
** ATL, Seattle, Washington

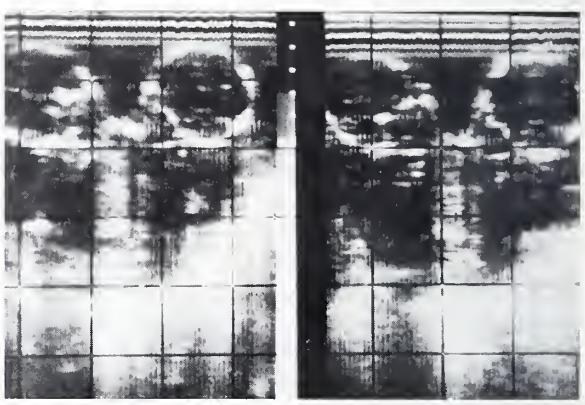

Figure 1. Case 1: Joined spines and two heads.

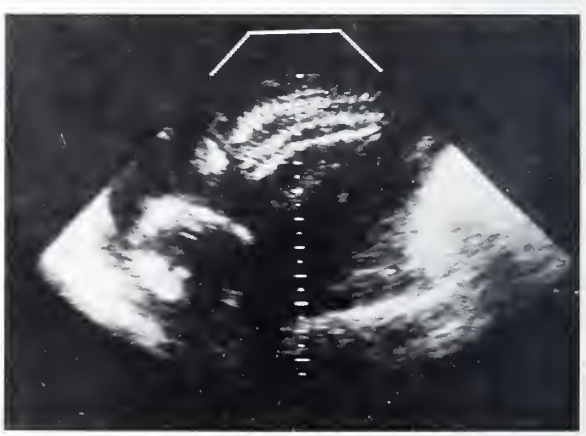

Figure 2. Case 1: Complex spinal arrangement.

elected immediate termination by prostaglandin suppositories. Spontaneous delivery of an Apgar 0, 490-gram male dicephalus dipus dibrachius occurred after 12 hours. The placenta weighed 205 grams. There was a single umbilical cord.

At the couple's insistence and because of the husband's alleged exposure to Agent Orange in Vietnam, chromosomal analysis was performed on the couple and on pericardial tissue from the anomalous fetus. Maternal karyotype was 46XX; paternal, 46XY, and there was no growth in the fetal tissue flask.

Case 2, M. W., is a 21-year-old black primigravida whose LMP was October 30, 1981. Pregnancy registration occurred at 14 weeks' gestation. Clinical history revealed a minor seizure disorder not requiring medication. There was no history of drug or alcohol abuse.

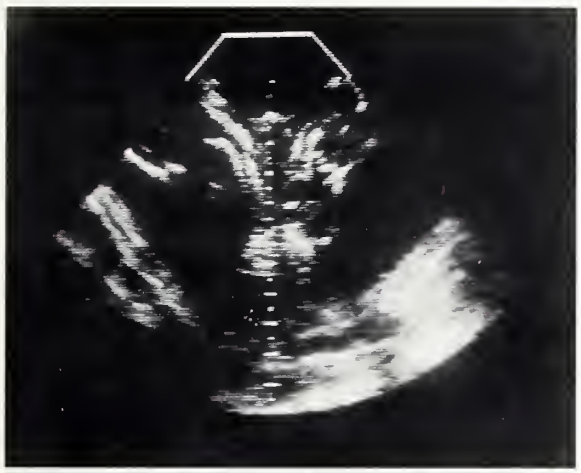

Figure 3. Case 1: View showing fused spines with two heads attached.

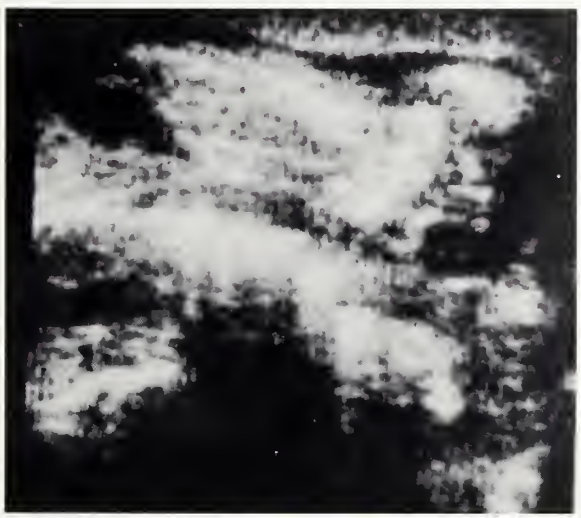

Figure 4. Case 2: Complex spinal arrangement.

Initial clinical examination was normal except for a size-dates discrepancy, the uterus being compatible with an 18-week gestation.

The sonogram was abnormal (Figure 4), and a diagnosis of dicephalic monster was made. Patient was informed and admitted for termination by intrauterine instillation of saline. The fetus is seen in Figures 5 and 6.

Discussion

Conjoined twins result from either the development of two centers of axial growth on a single embryonic disk or the fission of the original embryonic area with the point of fission determining the degree or variety of malformation. The existence of conjoined twins is determined before the end of the second week after fertilization. There is an unexplained preponderance of female (75-90 per cent), and most are born prematurely and stillborn.[1,2]

An excellent classification originally was developed by Welder in 1904, and is based on the area of union. The classification has been enlarged and rearranged but basically remains intact. Conjoined twins are generally externally symmetrical. The viscera, however, are most often neither identical nor mirror images, and are often single. Postpartum survival depends on the de-

Figure 5. Case 2: Posterior view.

gree and location of the union, and the presence of separate hearts.

Prepartum recognition of conjoined twins depends on maintaining close early pregnancy surveillance for twinning and other growth abnormalities, and prompt confirmation of suspicions by ultrasound.[3] Both cases were diagnosed at 17 weeks with ultrasound, far earlier than possible with any other current modality. Sonographic criteria for the diagnosis of conjoined twins have been presented and expanded by several authors[4] (Table).

Figure 6. Case 2: Anterior view.

Following diagnosis, obstetrical management should be a team decision based on parental attitudes and desires, and potential for infant survival as judged from estimates of fetal size, point of union and sonographic estimation of fetal soft tissue components.

Cesarean section is the method of choice for delivery regardless of potential for survival except where the twins are small enough to pass through the birth canal without posing significant damage to the mother. Where survival is deemed possible, delivery should occur at a high-risk center where immediate, sophisticated neonatal care is available.

TABLE

Roentgenographic and Sonographic Features of Ventrally Fused, Conjoined Twins

Finding	*Diagnosis Made by Roentgenography*	*Ultrasound*
Fetal body parts on the same level	X	X
Constant relative fetal position	X	X
Fetal extremities in unusual proximity	X	X
En face fetal position	X	X
Bibreech, less commonly bicephalic presentation	X	X
Hyperextension of one or both cervical spines	X	X
Nonseparable, continuous external skin contour		X
Single heart sound by Doppler		X
Solitary large liver and heart		X
Multiple shared omenta		X
Solitary umbilical cord with>3 vessels		X

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Medical Grand Rounds

From the West Virginia University Medical Center

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Osteoporosis

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The type of person most likely to be affected by osteoporosis is: the thin, small-boned woman who smokes, exercises little, drinks no milk and who is postmenopausal. Other diseases which may cause osteoporosis should be considered in the differential diagnosis. The etiology of the disorder is unclear but may involve altered vitamin D metabolism. Supplemental calcium, exercise and estrogens may prevent the disorder. Therapy with calcium, estrogens and perhaps fluoride decreases the rate of fracture.

OSTEOPOROSIS and its complications involve a very large number of patients. Its distribution is worldwide but there are regional differences in occurrence. Although there are multiple theories of pathogenesis, it may be thought of as being a disease of civilization; the advent of labor-saving devices and urbanization have decreased the amount of exercise required for living. At the same time, public health measures and immunizations have extended the average life span. Inactivity and old age are two important predisposing factors involved in the most common osteoporosis. There are many different kinds of osteoporosis but I will consider primarily the postmenopausal and senile varieties.

Consideration of an individual patient is valuable in defining the characteristics of the disorder but does not give a picture of the enormity of the problem. It has been estimated that by age 75, nearly all women have bone mineral density which is below the fracture threshold of hip fractures. A brief survey of the orthopedic ward quickly demonstrates that hip fracture is a common disorder—especially among elderly women. It has been estimated that osteoporosis accounts for 70 per cent of the one million fractures which occur annually. The financial cost of over $1 billion is substantial even in our inflationary times. These direct hospital costs do not include additional expenditures for home help, medications and braces.

The type of person most frequently involved with osteoporosis is an elderly woman of somewhat small stature. The physicial characteristics of the woman who has osteoporosis compared to the one with osteoarthritis were studied by Dequeker *et al.*[1] Although height and arm span were not different, the patients with osteoarthritis were heavier and had greater skin fold thickness. They also had a greater muscle mass and were stronger as measured by strength testing. It would seem that you could choose your bone disease—eating, and increasing your strength gives you osteoarthritis while being thin and weak gives you osteoporosis!

Although osteoporosis is worldwide, the woman most susceptible is of western European or English extraction. Six per cent of the world's population is over 65. This figure is 14 per cent in western Europe, 10 per cent in North America,

and 12.2 per cent in West Virginia. These elderly persons are those affected by osteoporosis. Caucasians appear to have more disease than blacks. In one study this appeared to be due, at least in part, to more exercise in blacks, so the difference in incidence may not be entirely racial. Vegetarians appear to have less osteoporosis than omnivores. A diet high in calcium seems to offer some protection but a high-protein diet is associated with more disease. I'll consider possible reasons for these regional and dietary differences later.

Clinical Presentations

The patient with osteoporosis usually presents for medical attention in one of two ways. She may have the acute pain of a bone fracture or the more chronic syndrome of a backache. The areas of the skeleton involved most often are the spine, the hip and the forearm.[2]

Vertebral body fractures are compression fractures which occur with minimal or no recognized trauma. Coughing or straining to lift a light object may result in acute collapse with pain in the area due to associated paravertebral muscle spasm. These fractures wedge anteriorly so that nerve roots, because of their posterior location, are not usually injured. These fractures are most often noted in the lower thoracic and upper lumbar areas. Next most common is midthoracic and lower lumbar involvement. Although any area of the back may have a fracture, the cervical and upper thoracic vertebrae are rarely involved.

The pain of an acute fracture may be severe, but usually responds to analgesics and two to three weeks of bed rest. This acute syndrome may be followed by a more chronic aching which is worsened by prolonged standing. Multiple fractures which are either clinically apparent or asymptomatic eventually result in kyphosis—the so-called "dowager's hump." If the kyphosis is severe, the abdomen is protuberant and the ribs may rest nearly on the pelvic brim. In this circumstance, much of the chronic aching may be due to poor posture and respond to appropriate exercise. The morbidity of the spinal deformity is further compounded by the difficulty in finding attractive clothing which fits well and disguises the abnormality.

Femoral Head, Neck

The femoral head and neck are the sites involved most often after the spine. Nearly 200,000 persons sustain hip fractures each year in the United States. Over 75 per cent of these are due to associated osteoporosis. Woman are involved twice as frequently as men. Although these fractures apparently are well treated with nails or prostheses, the patients themselves may not fare so well. In one study, one sixth of patients with hip fractures died of complications.[3] Those involved are usually elderly, and have other serious medical illnesses that may be worsened irretrievably by another insult. Femurs may fracture with minimal trauma or a fall from a standing height.

By age 75 nearly all women have a bone mineral density below the fracture threshold, defined as the lower limit of normal at age 20. This is not true for men. Yet, not all old women have fractures. One study suggested that those who had fractures actually sustained more falls than those who didn't perhaps because of associated cardiac arrhythmias or cerebro-vascular disease which predisposed them to dizziness and postural instability.[4]

After vertebral and hip fractures come forearm fractures. Among young persons, males and females are affected equally with trauma being important in this age group. Among older persons, women are much more commonly affected than men. Such fractures also occur following minimal trauma.

Idiopathic, postmenopausal or senile osteoporosis, although accounting for the majority of compression vertebral or hip fractures, are not the only disorders which cause osteoporosis. In the patient who sustains such a fracture, other possibilities should be considered. The Table lists most of the important differential diagnoses.[5] Primary hyperparathyroidism occurs more commonly in women than in men. It presents in middle-aged, postmenopausal women as diffuse osteoporosis. All of these diagnoses should be easily identified if they are considered among the possibilities.

Diagnosis

If an acute compression fracture occurs, there may be no changes on plain x-rays until three to four weeks after the event. Eventually, however,

TABLE

Common Causes of Osteoporosis

Postmenopausal osteoporosis	Malignancies:
Senile osteoporosis	Lymphomas
Cushing's syndrome	Multiple myeloma
Hyperparathyroidism	Leukemias
Hyperthyroidism	Metastatic Carcinoma
Hypogonadism	Osteogenesis Imperfecta
Osteomalacia	Paget's Disease of Bone

the plain films will demonstrate abnormalities. It would seem, however, more desirable to make a diagnosis of significant osteoporosis prior to a fracture. The plain or magnified x-rays may not be especially useful in identifying early osteoporosis because at least 30 per cent of the bone mineral density must be lost before a change is apparent. Furthermore, the small changes expected to occur in a short period of time or with therapy would not be appreciated. These problems led to the development of more sensitive techniques for the measurement of bone mineral density.

Photon absorptiometery is one of these. A source of either Iodine 125 or Americium 241 is placed on one side of the bone to be measured. A device on the other side of the bone measures the amount of radioactivity which passes through the bone. The greater the amount of bone mineral present, the less radioactivity is detected. This method is useful for measuring bone density in the forearm. Unfortunately, measurement of bone in the forearm is not ideal for several reasons: 1) The bone in the forearm at midshaft is primarily cortical—at a more distal location it is 25 per cent or more trabecular bone. This is unlike the distribution of trabecular bone in either the spine or femur. The lumbar spine has greater than 66 per cent trabecular bone; the femur, in the intertrochanteric region, is 50 per cent trabecular bone;[6] and 2) There has not been a good correlation found between measurements of bone mineral content at one site compared to another. In fact, Kovarik *et al.*[7] found a negative correlation between forearm densitometry measurements and quantitative histological studies of the iliac crest bone in elderly women.

So despite the advantages of reproducibility, convenience and very little patient morbidity, photon absorptiometry is much less than ideal for determination of bone mineral content in areas most likely to be involved with fractures—the spine and hip.

Modification of the absorptiometry technique has been developed by the Mayo Clinic.[4] Use of the isotope 153 of Gadolinium has allowed measurement of the bone mineral content of the spine and hip. This isotope has two energy levels, 44 and 100 kev; this allows subtraction of the soft tissue.

Information obtained by CT scanning can be quantitated by use of a computer.[8] The examination may be repeated for followup of therapy or progression, and appears to be able to detect bone mineral loss of five per cent. There are some technical problems with respect to locating the same area for repeat measurement and artifact due to the density of bone.

Bone biopsy is the definitive method of determining mineral content. Biopsy at one site, however, may not be representative of the entire bone, and is invasive. In metabolic balance studies, calcium intake and excretion are measured. The difference between intake and excreted calcium presumably is deposited in bone. This method is expensive, time consuming, and not feasible for a free-living population.

The diagnosis of osteoporosis may be made using one or more of these techniques if it is recognized that none of them is free of problems.

Etiology

Fuller Albright described 50 patients with osteoporosis.[9] All but 10 of them were postmenopausal women. He postulated that there were two forms of osteoporosis: the postmenopausal and the senile type. These categories also have been used by Riggs *et al.*[4] The postmenopausal group accounts for five to 10 per cent of the total, and these women sustain primarily vertebral fractures 15 to 20 years after menopause. They appear to have lost excessive and disproportionate amounts of trabecular bone.

The second group involves persons over 75. These people have either hip or vertebral fractures or both. This type includes over 50 per cent of old women and about 25 per cent of old men. The bone loss appears to be only slightly more than in an age-matched control group without osteoporosis. Most of the group of women with hip fractures fall within the normal range for bone mineral density.

Classification of osteoporosis subjects into these two groups helps to explain some of the observations which have been made. Cross-sectional studies of persons from young to old age have shown a gradual loss of bone mineral content with aging.[4] There does not appear to be a change in the curve at the time of menopause or shortly thereafter.

Yet it also has been shown that the rate of bone mineral loss following either surgical or natural menopause is rapid for three to five years and then slows.[10] Inclusion of a small group which loses more bone mineral at this time may not affect the curve of gradual bone loss which occurs with age.

Another question to be answered is whether persons who develop symptomatic osteoporosis are in some way different from older people who do not. In other words, is the bone mineral loss

pathologic? Bone reaches a maximum mass at maturity in both sexes. This absolute mass is related to body size—that is, it is larger in those of greater stature. The body size of men is on the average greater than that of women. If both groups lose bone mineral at the same rate, women will reach the fracture threshold sooner because they start with a smaller absolute mass. Men with small stature and a small bone mass may be similarly affected. In this theory, osteoporosis is a normal accompaniment of aging — if you start with a small bone mass and live long enough, you most likely will be affected.

Support for the second theory that this involves abnormal bone loss comes from cross-sectional studies. As we've seen, those with fractures may fall outside of two standard deviations of the age-adjusted bone mineral content.

Causes of Bone Loss

If the rate of bone loss is more than normal, what is the reason for this increase? Dietary habits, inactivity, abnormalities in hormone or vitamin levels have all been proposed as etiologic factors.

Examination of the diets of those with osteoporosis compared to normal subjects has shown that affected persons eat less calcium-containing foods. Dairy products are the primary dietary source of calcium. A diet with no dairy products contains only about 300 mg of calcium. Eight ounces of milk contains 240 mg calcium, and five slices of American cheese have 600 mg of calcium. A National Health Survey in 1977 showed that postmenopausal women typically consume diets with less than 500 mg calcium daily.[11]

Possible reasons for this may include: a general decrease in food intake which occurs in the elderly due perhaps to a decrease in the senses of taste and smell. Another reason may be lactose intolerance which is not clinically recognized. Newcomer *et al.*[12] demonstrated that osteoporotic subjects had a higher prevalence of lactose intolerance than normal subjects. A study in Yugoslavia has shown an association between low calcium intake and fracture rates at all ages.[13] Such differences in patterns of food consumption may explain some of the regional differences in osteoporosis.

Furthermore, the rate of calcium absorption is less in postmenopausal women when they are compared to premenopausal women. This alteration is reversible with estrogen therapy, suggesting that estrogens have at least a permissive role in intestinal calcium absorption.[14]

Foods eaten along with calcium also may affect calcium absorption. The consumption of processed foods such as macaroni and flour is common among elderly subjects. These foods are relatively high in phosphates which may complex with calcium in the gut and impair its absorption.

Groups of people such as Eskimos whose diet contains large amounts of meat tend to have a lower bone mineral content than age-matched white subjects.[15] One mechanism postulated to be involved is that ingested protein promotes a systemic acidosis. This is buffered by bone but calcium which is mobilized is lost in the urine. The regular occurrence of this sequence with meals would then result in a negative calcium balance.

Vegetarians have less osteoporosis than those who eat meat. A mechanism postulated to protect vegetarians is that estrogens are recycled in the intestine with the increased estrogen level being protective. There is little experimental support for this theory but omnivores have twice as much osteoporosis as vegetarians.[16]

Role of Hormones

The level of estrogens has not been found to be different in most studies of patients with osteoporosis compared to normal subjects. After menopause the major portion of circulating estrogens is from peripheral conversion, with a smaller contribution from adrenal secretion. Comparison of 30 patients with one or more vertebral fractures with controls matched for age and years since menopause found no significant difference among the cortisol, androgen or estrogen levels.[17]

The status of the hormones which are involved in regulation of calcium are of particular interest in the investigation of osteoporosis. Parathyroid hormone increases mobilization of calcium from bone under the stimulus of hypocalcemia, so measurements of this hormone are important. Examination of the intact hormone, the amino and the carboxyl fragments reveals that all show an increase with age—as much as an 80-per cent increase from age 20 to 90.[18] Despite the increase in PTH, serum calcium level remains the same. Renal function decreases with age but the change in PTH was independent of this. The PTH increase has been postulated to be due to the impaired intestinal calcium absorption which occurs with age. The PTH level may be somewhat lower in patients with osteoporosis; this perhaps represents a normal feedback response to mobilization of calcium from bone due to another process.

As mentioned, calcium absorption decreases with age. Absorption of dietary calcium is responsive to vitamin D. Serum levels of $25OHD_3$ are no different between osteoporotic and normal subjects. On the other hand, levels of 1,25 $(OH)_2D_3$ are significantly lower in those with osteoporosis.[19] In normal young subjects there is a correlation between calcium absorption and serum 1,25 $(OH)_2D_3$ levels but this relationship is lost in subjects with osteoporosis. The addition of the 1 hydroxyl group to vitamin D is stimulated by parathyroid hormone in normal subjects. The conversion is defective[20] in patients with osteoporosis, suggesting that there is a block in the 1-hydroxylation step. This defect would explain the decrease in intestinal calcium absorption seen in elderly osteoporotic subjects. Furthermore, the administration of 1 α or 1,25 $(OH)_2D_3$ increases calcium absorption.

Calcitonin is secreted in response to hypercalcemia and increases the deposition of calcium in bone. Serum calcitonin levels decrease with age.[21] Furthermore, the response to a calcium infusion also is blunted with increasing age. Whether these responses are primarily involved in producing osteoporosis or are secondary to it remains to be determined. Calcitonin has, however, been used to treat osteoporosis with some response.

Other factors which may be involved in osteoporosis are smoking and inactivity. Smokers have a lower bone mineral content than nonsmokers.[22] This may in some way relate to the systemic acidosis and its buffering by bone which occur with smoking.

Inactivity of either a limb or the entire body may exacerbate bone loss. This becomes an important consideration in prescribing bed rest for an elderly person. The bone loss becomes significant after about three months of immobilization, with the rate of loss four per cent per month compared to 0.1 per cent per month with age alone.

Therapy

Obviously, it would be best to prevent osteoporosis, if possible, rather than attempt to treat the complications. Of the possibilities, supplemental calcium and exercise are probably the only ones without substantial risks. Were the etiology of the disorder better defined, an outline of preventive measures would be relatively straightforward.

Unfortunately, many patients come to medical attention only after they have sustained an atraumatic fracture. This means that the osteoporosis is already far advanced. Therapies have been difficult to evaluate because of the inability until recently to measure small changes in bone mineral content. It furthermore is difficult to achieve new bone formation; in some circumstances, the best to be hoped for is a stabilization or a decrease in the rate of bone loss.

The difference in prevalence between the sexes suggests that estrogenic hormones play a significant role and may be useful in treatment. The use of estrogens to decrease the rate of forearm and hip fractures has been demonstrated in several studies. They appear to have the most effect if given within five years of menopause. A dose of at least 0.625 mg of conjugated estrogens is required to achieve this effect, with lesser amounts unable to reverse rapid bone loss.[23] If estrogens are effective, is their use always indicated? After a brief flurry of estrogens for everybody—in the "forever young" era of the 70s—their popularity decreased markedly when an association was noted between estrogen therapy and endometrial carcinoma. More recent studies have suggested that this increase in carcinoma may be reversed by the periodic administration of a progestational agent to cause sloughing of the endometrial lining.[24]

Other complications of estrogen therapy include estrogen-dependent breast tumors, atherosclerotic cardiovascular disease, deep vein thrombosis and pulmonary embolism. Hypertension, diabetes, and hyperlipidemia may be worsened. Migraine headaches and seizures may be precipitated, and, rarely, acute pancreatitis develops. Lipids appear to be altered favorably in postmenopausal women treated with estrogens. Consideration of estrogen therapy for an individual patient must take into account predisposing and pre-existing diseases in a risk/benefit format.

Supplemental calcium either as food or medication may be used to treat osteoporosis. The major complications are hypercalcemia and constipation, and perhaps nephrolithiasis. Calcium balance is negative in postmenopausal women with a loss of 43 mg daily.[25] The daily requirement in this age group is 1.5 gm. Supplementation of the diet with one gm of elemental calcium has been shown to decrease bone remodeling. Similar results have been obtained whether the calcium is given as food (cheese and milk) or medication.

Vitamin D, Activity

The place of vitamin D in treating osteoporosis is unclear. When it (50,000 units twice weekly) was combined with estrogens or calcium it appeared to offer no additional benefit. Some

investigators have suggested that there may even be an increase in fractures. Therapy with 25-OH D_3 results in an increase in calcium absorption in some but not all patients. This response appears to depend on an associated increase in 1,25 $(OH)_2D_3$. Therapy with 24, 25$(OH)_2D_3$ was shown to increase calcium absorption initially, but the response was transient and returned to baseline by six months. Therapy with 1,25 $(OH)_2D_3$ improves[19] calcium absorption. One of the concerns about using vitamin D is that if the diet is deficient in calcium, calcium may actually be extracted from bone rather than deposited. If Vitamin D is used, is probably should not be used alone.

Activity is an important factor in maintaining bone mineral content. Immobilization of adults for three months causes a 14-per cent trabecular bone loss. Weight-bearing exercises such as weight lifting promote more bone formation than non-weight-bearing ones such as swimming. Even so, an exercise program of aerobic exercises for one hour three times weekly promoted a positive calcium balance in postmenopausal women.[26] Three theories have been suggested as to how muscle activity affects bone: 1) a direct neural effect, 2) an indirect effect due to vascular and blood flow changes, and 3) mechanical stress and muscle tension in some way converted to biochemical effects on increasing mineral deposition.

The type of exercises done is of some importance. Extension exercises are recommended to improve posture and strengthen abdominal musculature. Flexion exercises may in fact increase the amount of anterior vertebral wedging compared to no exercises or extension exercises. The exercise prescription should be tailored clearly to the individual's disability and associated diseases.[27]

Other Therapies

Fluoride therapy may benefit some patients. The response is variable, however, and in one large study of 55 patients, 40 per cent had an increase in bone mass and a decrease in fracture rate.[28] Adverse reactions were common and caused some patients to discontinue therapy. Fluoride or a modified molecule may be of use in the future after its beneficial effects have been better documented. It, and perhaps estrogens and androgens, may increase bone mass.

Calcitonin therapy has been reported to improve symptoms and promote a positive calcium balance.[29] Its effect, however, was not entirely clear because in the study it was combined with supplemental calcium and there was no control group. One of the obvious disadvantages is that it must be given parenterally.

Androgens and thiazides have been reported to be of some value. The effect of thiazides in maintaining bone mineral content appears to be transient.[30] Androgen therapy may be associated with the development of hepatoma or peliosis hepatitis. It, as stanozolal, changes lipids in an undesireable direction—HDL decreases.[31]

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Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing the most commonly known trade-name drug of that designation. In addition, a listing of all generic drugs mentioned in the article, with their trade-name equivalents, should appear at the end of the article.

A short abstract summarizing the manuscript should be included. This should be typed in double space on a separate page.

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Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for reproduction should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. Cost of printing black and white photos in excess of 4 will be billed to author, and no more than 25 references will be published free of charge to the author. A legend should be provided for each illustration and, preferably, attached to it.

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A message from . . .

The President

A TIME FOR ACTION

I have become very concerned about the plight facing our state-funded colleges and universities. The faculties have not had an increase in salary for the past two years. One only has to discuss briefly this issue with faculty throughout the university community to understand that morale may have reached its lowest point. Realizing that this problem affects each and every department within the college and university community, I will focus upon the medical schools to illustrate several points.

What has been the effect of the salary freeze upon our medical schools? Data from WVU Medical School illustrate that salaries of the basic science faculty are in the lower 20th percentile when compared to other medical schools. The clinical faculty is below the median even though the WVU Medical Practice Plan provides 50 per cent of the salaries for the clinical faculty. The clinical faculty at Marshall Medical School is also in the lower 20th percentile when compared to other public medical schools. Due to the current salary freeze, it is becoming more and more difficult to retain and to recruit quality faculty.

Data from the WVU Medical School indicate the significance of this disturbing trend in inadequate faculty compensation. The number of basic science faculty lost has doubled in the past two years when compared to the preceding two-year period. Clinical faculty losses during the past four years have averaged approximately 30 positions per year. The losses on the clinical faculty have been blunted by practice plan support, but there is evidence that the losses of clinical faculty this year may reach an all-time high. Many of the faculty who have resigned have not entered private practice, but have accepted positions at other medical schools with a substantial increase in salary.

What is the reason for inadequate funding of our university and college faculties and our medical schools? The economic reality is that we do live in an environment of scarce resources. Our revenues are unable to support two medical schools and an osteopathic school. Furthermore, the GMENAC Report has predicted an oversupply of 70,000 physicians by 1990 and 140,000 physicians by 2000. Are we producing more physicians than are needed? The data seem to support this conclusion.

We can no longer continue to increase taxes to finance additional services. The state income tax is the fourth highest in the country, and the business environment in West Virginia has not been conducive to attracting new industry. In fact, many of our higher-income individuals are planning to exit the state because of these various impediments to economic growth. The responsibility for facing the issue of inadequate funding of our state colleges and medical schools must be faced by our Legislature. It is time for a thorough analysis of the alternatives without regard to political expediency.

Tough decisions must be made regarding the medical schools which necessarily will affect the structure of the separate schools. The issues are complex, and the cost of medical education is not the only criterion for analysis. The medical schools themselves become an entity which is so important to the delivery of quality health care since these institutions have a positive impact upon the community and the state.

The public should hold the West Virginia Legislature accountable if it is unwilling to face these issues, and to develop workable solutions. There must be a consolidation of resources if we are to retain quality education in our medical schools. The West Virginia State Medical Association is willing to assist in this endeavor. Perhaps, a task force consisting of representatives from the Legislature, medical schools and the Medical Association should be formulated to address this problem. This should be a priority for the legislative session in 1984. Without immediate action, the quality as well as the continued existence of our medical schools is certainly in question.

Carl R. Adkins, M. D., President
West Virginia State Medical Association

The West Virginia Medical Journal

Editorials

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author shall be held entirely responsible. Editorials printed in The Journal do not necessarily reflect the official position of the West Virginia State Medical Association.

WORK TO BE DONE

"We owe it to the public to police ourselves a h --- of a lot better" . . . More and better peer review—long overdue" . . . More active and direct response to complaints regarding colleagues" . . . "More aggressive response to media criticism of the medical profession" . . . "More cooperation between the State Medical Association and specialty groups" . . .

These were just a few of the responses, recommendations, criticisms, observations, etc., volunteered by the Medical Association membership in a recent survey. The survey went to 2,100 members, and the response in excess of 23 per cent at this writing would be regarded as excellent to fantastic by any professionals in the study field.

Only one response could be classed as inappropriate, or of the "crank" variety. Physicians obviously, in very large measure, took time to digest the questions asked, and to provide solid, intelligent answers.

Did the survey provide anything really new? Maybe not, from an overall standpoint, although a detailed analysis of the 500 or so responses will require time. The leadership, and particularly Carl R. Adkins, M. D., the Association President, will be reviewing the results very carefully.

As practicing physicians, you told us that communications with the public need improvement to a significant degree. You want specific additional attention, also, to legislative activities (although hard work in that area was reflected in a generally favorable reaction); to litigation and other legal issues (another area given staff priority, in particular, in recent years); and, of course, to peer review.

You gave significant passing remarks to Association efforts in the area of professional liability insurance. Again, you had concerns about effectiveness with regard to public attitudes about physicians, although a candid assessment must show that such an item must in large measure be in the hands of individual physicians in their day-to-day practice.

Other major concerns, although your overall assessment was far from completely negative, included onerous government regulations; emergence of mid-level, non-M. D. practitioners; and the cost of medical care. Each of these represents a most difficult challenge, for a number of reasons, for the Medical Association as an entity.

Physicians did not hesitate, in their responses, to assume personal responsibility for shortcomings. In measuring the Association as ineffective in a number of areas, one member said he did not want to imply that no effort has been made, or that significant thought has not been given to issues such as regulations and costs.

"The communication between Organized Medicine and various governmental and legislative bodies is often adversarial—neither side understands nor appreciates the other," he wrote. "Administrators of these health programs often have no concept of health care delivery, but will tell you they do." He added:

"This frustrates the person or group delivering the health care, and increased friction develops. Physicians often do not appreciate or understand the role of these administrative bodies. I frankly see little hope for stability in health care for the next few years (but) keeping a diaglogue, cool head and being persistent might lead us to a better system."

Another physician cited "apathy" on the part of the general Association membership and what he saw as the inability of medical organizations, in general, to influence legislation and or public opinion. "We really have little to say about medical costs (except our individual fees) as long as we have no control over and little interest in hospital costs," he added.

Again, with the Annual Meeting behind staff and leadership, more detailed attention will be given the survey results — and appropriate reports will be given the membership. You seemed to feel that overall performance of the

Association; representation of and responsiveness to the membership, and communications with the profession itself have been good.

Now you have pinpointed in at least more specific fashion other things that must be done, or things that need to be done better. Staff and leadership will "turn to" on those items.

Amid all of the controversy and discussion, logical and otherwise, surrounding health care costs, one question seems more and more pertinent. Shouldn't more attention be given to the contribution, if that's the proper word, the public makes to the problem?

THE PUBLIC FACTOR

As those such as David A. Smith, M. D., Medical Editor of *Pennsylvania Medicine*, have observed, many recognized risk factors for disease are, in fact, bad habits which in turn create health care costs which potentially are avoidable.

Smoking perhaps is one of the largest cost-generating factors in terms of lung and bronchial cancer, chronic obstructive lung disease, heart disease and even birth defects, he noted.

Drug and alcohol abuse generates unnecessary medical costs. Liver disease, accidents and personal neglect contribute to avoidable medical expenditures. All of which means that patients *do* exercise some control over health care costs, and *could* bring such costs down substantially by changing a few of their habits.

But in the meantime, Americans attribute the high cost of medicine to physicians; the government looks to hospitals; hospitals point to physicians and regulatory agencies; physicians point to high malpractice insurance premiums, government paper-pushing and regulations.

As for the public, it goes its merry and unconcerned way—smoking, drinking and adding a generally unnoticed, but significant, contribution to the whole cost problem.

The ever-changing health care delivery climate has produced a wide variety of health insurance plans. Under some now being marketed, there may be payment for care only when that care is rendered by certain selected physicians and/or institutions.

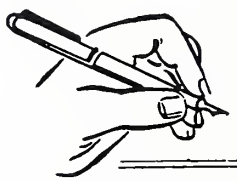
CONCERN FOR QUALITY

These developments have brought increasing concern among practicing physicians as to the degree to which some of the health insurance plans might impair continuity of care by preventing physicians from treating their patients in hospitals.

The American Medical Association has taken the lead in monitoring the new plans closely, especially those such as recently developed preferred provider arrangements which utilize selective mechanisms.

A number of activities addressing alternate delivery systems features the AMA effort. A technical assistance document likewise is being developed for use by physicians and medical societies in evaluating preferred provider organizations and similar delivery systems.

All of this represents just one more general example of the sifting sands in medical and health care. And it underlines the necessity for continued emphasis on the one thing that really counts—the constant availability of *quality* care. Sometimes one can lose sight of the really vital component of a whole. This must not happen here.



Our Readers Speak

Doctor, Nearing 100, Reports Treatment

I have been a sufferer from senile pruritus 15 or more years. I consulted four different dermatologists, all of whom confirmed the diagnosis of senile pruritus, and all of them treated me with local applications of salves and lotions. These gave some relief from the itching, but no one ever mentioned internal drug treatment.

Three years ago I got to wondering if itching was not a form of mild pain. If it is a form of pain, it should be amenable to and treatable with drugs taken internally. I decided to find out by taking aspirin. I experienced complete relief that very day by taking two aspirin capsules—the itching would completely disappear in about 50 minutes.

Since that day I have used aspirin many times internally. I have now changed from aspirin to Extra Strength Tylenol capsules. I found out that it relieved the itching the same as aspirin in 40 to 50 minutes. I changed because I was having heartburn, and it has never failed to work.

Since I retired from the practice of medicine several years ago, the only patient I had to try the effects of aspirin and Tylenol in the treatment of senile pruritus was myself. I have no doubt the drug would work on other people as it has on me. I also found that if I would take two capsules of Extra Strength Tylenol regularly every four hours I would have no itching at all during that time.

On January 20, 1984, if I live, I will be 100 years old. I will be the first West Virginia doctor to live to that age.

I would appreciate it if . . . this report could be published in *The West Virginia Medical Journal.*

B. S. Brake, M. D., D. D. S.
201 Point Street
Clarksburg 26301

GENERAL NEWS

Doctor Adkins New President Of Medical Association

Dr. Carl R. Adkins of Fayetteville has assumed duties as the new President of the West Virginia State Medical Association.

Doctor Adkins was installed as President by Dr. Harry Shannon of Parkersburg, the retiring President, at the concluding session of the House of Delegates on Saturday, August 27, during the 116th Annual Meeting of the Association at the Greenbrier in White Sulphur Springs. He is Director of Emergency Services at Raleigh General Hospital in Beckley, and President of Physician to Physician Associates, a medical management consulting firm.

The official Medical Association convention registration totaled 381 and included 340 physicians, down slightly from a total registration of 393, with 351 physicians, in 1982. Auxiliary registration was 143.

Convention activities began with a meeting of the Association's Council on Thursday, August 26. (See story on the Council meeting elsewhere in this issue of *The Journal.*)

Doctor Shannon presided at the Thursday and Saturday sessions of the House. He automatically became Chairman of the Council for the new Association year, succeeding Dr. John B. Markey of Charleston.

Elevated to President Elect from Vice President was Dr. Carl J. Roncaglione, South Charleston orthopedic surgeon, who will be installed as President during the 1984 Annual Meeting.

Doctor Morgan Vice President

Dr. David Z. Morgan of Morgantown was elected Vice President, and Dr. George A. Shawkey of Charleston, a pediatrician, was re-elected Treasurer. Doctor Morgan is Professor of Medicine and Associate Dean for Student Affairs at the West Virginia University Medical School.

Dr. Jack Leckie of Huntington was elected to a two-year term as a Delegate to the American Medical Association, with Doctor Markey elected as Alternate Delegate.

Three new Council members were elected, with six other physicians re-elected to two-year terms. There being no successor nominated for Dr. Nabal B. Giron of Romney (District V), President Adkins will appoint the Councilor for that vacancy. Doctor Giron was eligible for, but declined, nomination for re-election.

The three new Councilors are Drs. Charles E. Turner of Huntington, Echols Hansbarger, Jr., of Charleston and David F. Bell, Jr., of Bluefield.

Re-elected were Drs. Antonio S. Licata, Weirton; Stanard L. Swihart, Fairmont; Roland J. Weisser, Jr., Morgantown; Cordell A. de la Pena, Clarksburg; John D. Mathias, Buckhannon, and Jean P. Cavender, Charleston.

Holdover Councilors

Holdover Councilors whose terms will expire in 1984 are Drs. D. L. Latos, Wheeling; George A. Curry, Morgantown; L. Mildred Williams,

Carl J. Roncaglione, M. D.
President Elect

Charles Town; Robert R. Rector, Elkins; Michael J. Lewis, St. Marys; Thomas F. Scott, Huntington; Sherman E. Hatfield, Charleston; George W. Hogshead, Nitro; Norman Wayne Taylor, Beckley; and Diane E. Shafer, Williamson.

Under the terms of the Association's Constitution, Doctor Markey, the Council Chairman last year, becomes Council-At-Large for 1983-84; and Dr. L. Walter Fix of Martinsburg, the Association President three years removed, will serve as Junior Councilor during the period.

The House adopted two sets of Constitution and Bylaws Amendments dealing with Medical Association membership, and a Bylaws Amendment creating a new standing committee on Audit and Budget. One set of amendments will make residents in their first year of approved training eligible for Association membership; the other amendments will open membership to doctors of osteopathy who meet certain training requirements. (See separate story on Constitution and Bylaws Amendments elsewhere in this issue of *The Journal.*)

The House also adopted two resolutions, one requesting Governor John D. Rockefeller IV to consider funding necessary for further development of the state's air MEDEVAC program as a part of emergency medical care; the other endorsing the concept of an identical qualifying examination for licensing of doctors of medicine and osteopathy in West Virginia. The full texts of the resolutions appear elsewhere in this issue of *The Journal.*

Four-Year WVU Medical School Grad

A native of Holden in Logan County, Doctor Adkins is the first President of the State Medical Association to have been graduated, in 1972, from the four-year medical school at WVU. Doctor Adkins also received his undergraduate degree from WVU in 1965, and has a Master of Business Administration degree from Wake Forest University.

For 10 years, Doctor Adkins was a family practitioner, and is a Diplomate of the American Board of Family Practice.

He is a member of the Board of Directors of the West Virginia Medical Institute, Inc.; a member of the West Virginia Academy of Family Physicians and the American Medical Association; a past President and Secretary of the Fayette County Medical Society; a former Chief of Staff at Raleigh General Hospital, and a Federal Aviation Administration flight examiner. He also is a Director of Fayetteville Federal Savings and Loan Association, and a former Elder in the Fayetteville Presbyterian Church.

Doctor Adkins and his wife, Susan, have one son, Jonathan.

Doctor Roncaglione, born in Oak Hill, was Chairman of the 1982 Annual Meeting Program Committee. He currently is a member of the State Medical Association's Legislative, Medical Economics, and Medical Aspects of Sports committees.

Two Terms on Council

The new President Elect, who served two terms on the Association's Council (1974-80), was graduated from Emory and Henry College. He received his M. D. degree in 1951 from the Medical College of Virginia.

(continued on next page)

Delegates Name Doctor Holroyd To Honorary AMA Post

The West Virginia State Medical Association's delegation to American Medical Association meetings now will have an honorary member.

Frank J. Holroyd, M. D., of Princeton will be succeeded next year by Jack Leckie, M. D., of Huntington as one of the state's two Delegates to the AMA House. Harry S. Weeks, Jr., M. D., of Wheeling is the other Delegate, with Joseph A. Smith, M. D., of Dunbar, and John B. Markey, M. D., of Charleston serving as Alternate Delegates.

But in line with a motion adopted by the State Association's House of Delegates at the Greenbrier in August, Doctor Holroyd will serve as "an honorary member to all AMA meetings, and his expenses will be paid by the West Virginia State Medical Association."

Doctor Holroyd's tenure as an AMA Delegate has been the longest on record—32 years, following his election at the Greenbrier in July, 1951, to succeed the late George F. Evans, M. D., of Clarksburg.

For several years, Doctor Holroyd has been the oldest sitting Delegate from the standpoint of continuous service. He was a power in AMA politics, along with his service to his state organization, successfully managing compaigns for AMA President Elect for the late Wesley W. Hall, M. D., of Nevada, in 1970 and the only West Virginian to hold the AMA's highest office, the late C. A. (Carl) Hoffman, M. D., of Huntington, in 1971.

Doctor Morgan, a native of Fairmont, was graduated from WVU, and received his M. D. degree in 1952 from the Medical College of Virginia.

He was Chairman of the 1983 Annual Meeting Program Committee, and is a member of the Association's Medical Economics, Medical Education and Hospitals, AMA-ERF, and Medical Scholarships committees.

Checks were given to Drs. Richard A. DeVaul, Dean, WVU School of Medicine, and Robert W. Coon, Vice President and Dean, MU School of Medicine, during the first House session. Doctor Shannon asked Mrs. Richard S. Kerr of Morgantown, 1982-83 President of the Auxiliary to the State Medical Association, to present the checks ($15,809.62 for WVU and $9,706.34 for MU) to Doctors DeVaul and Coon. The checks represented an annual contribution by West Virginia physicians and the Auxiliary to the medical schools through the Education and Research Foundation of the AMA (AMA-ERF).

Dr. Samuel P. Asper, President of the Educational Commission for Foreign Medical Graduates in Philadelphia, and Professor of Medicine, Johns Hopkins University, addressed physicians during opening exercises preceding the first general scientific session on Friday morning.

Membership Amendments Adopted by House

Two sets of Constitution and Bylaws Amendments dealing with Medical Association membership, and a Bylaws Amendment creating a new standing Committee on Audit and Budget were adopted by the House of Delegates during its annual session at the Greenbrier in White Sulphur Springs August 25-27.

One set of amendments will make residents in their first year of approved training eligible for Association membership. Under current state law, those first-year residents are not eligible for licensure (they work under educational training permits issued by the West Virginia Board of Medicine), and thus have not been eligible to join the Association.

The other amendments will open membership, of course as they might desire to affiliate, to doctors of osteopathy "if, and only if, they have completed an allopathic (LCGME) residency program and are board certified by an allopathic specialty board or have passed the FLEX examination or have become a Diplomate of the National Board of Medical Examiners."

As is the case with doctors of medicine licensed to practice in West Virginia, entry into the State Medical Association for qualified doctors of osteopathy also will necessitate membership in a component medical society of the Association.

Here is the Bylaws language establishing the new standing committee, with the provisions amending Chapter VIII, Section 6 of the Bylaws by adding a new subsection:

"(z) Audit and Budget. The Committee on Audit and Budget shall review annually Medical Association expenditures; evaluate them in relationship to organizational goals established or approved by the Council and/or the House of Delegates, and report its findings to Council. Auditing of the books and records of the Executive Secretary shall be done by a certified public accountant employed by the Treasurer under other provisions of these by-laws, with the audit report to be published in The West Virginia Medical Journal. The Committee also shall, within 60 days after the Association's Annual Meeting and in consultation with the Executive Secretary and Treasurer, prepare a budget detailing anticipated revenues and proposed expenditures for the next fiscal (calendar) year; with such budget to be submitted to Council for review and approval at its regular fall meeting. Further, the Committee shall review receipts and expenditures not less than semiannually as an additional step toward correlation between the budget and Association goals.

"The Committee on Audit and Budget shall have as its Chairman the Association Vice President, with other members to include the Immediate Past President, President Elect and two representatives of Council to be elected for a maximum term of two years each, with one member to be elected annually after the initial selection of one member for a two-year term and one for one year. The President, Executive Secretary and Treasurer shall be ex-officio non-voting members. The Committee on Audit and Budget shall have a Subcommittee on Internal Affairs to serve as called in such matters as job and salary classifications for Association staff and other duties as might be assigned. Such Subcommittee shall have as Chairman the Association President Elect with other members to include the Immediate Past President, Senior Councilor and two representatives to be appointed by the Council. The President and Treasurer shall be ex-officio members."

Continuing Education Activities

Here are the continuing medical education activities listed primarily by the Marshall University and West Virginia University Schools of Medicine for part of 1983 and 1984, as compiled by Charles W. Jones, Ph.D., MU Director of Continuing Medical Education; Robert L. Smith, M. D., WVU Assistant Dean for Continuing Education, and J. Zeb Wright, Ph.D., Coordinator, Continuing Education, Department of Community Medicine, WVU Charleston Division. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of The Journal.)

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the WVU Morgantown, Charleston and Wheeling campuses. Further information about CME activities may be obtained from: Office of Continuing Medical Education, MU School of Medicine, Huntington 25701; Division of Continuing Education, WVU Medical Center, 3110 MacCorkle Avenue, S. E., Charleston 25304; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 200 Eoff Street, Wheeling 26003.

Marshall University

Oct. 20-22, Educational Skills

Dec. 10, Sports Medicine Conference: A Program for Primary Care Practitioners

West Virginia University

Oct. 1, Morgantown, Issues in Geriatric Medicine*

Oct. 5, Charleston, Gastroenterology Update

Oct. 14, Morgantown, Ophthalmology Conference

Oct. 15, Morgantown, Common Problems in Nephrology*

Oct. 28-29, Morgantown, Fourth Diagnostic Ultrasound Conference

Nov. 3-5, Morgantown, Ninth Annual Hal Wanger Family Practice Conference*

Nov. 11-12, Morgantown, Fourth Sports Medicine Symposium*

Nov. 14, Charleston, Medicine and Ministry in Cooperative Patient Care

**Held in conjunction with WVU home football game.*

1984

Feb. 19-22, Snowshoe, Second Annual Vascular Surgery Conference

Regularly Scheduled Continuing Education Outreach Programs from WVU Medical Center/ Charleston Division

Buckhannon, St. Joseph's Hospital, first-floor cafeteria, 3rd Thursday, 7-9 P. M.—Oct. 20, "Management of the Myocardial Infarction Patient," Stafford Warren, M. D.

Nov. 17, "High-Risk Communicable Diseases and the Health Worker," Patrick Robinson, M. D.

Cabin Creek, Cabin Creek Medical Center, Dawes, 2nd Wednesday, 8-10 A. M.—Oct. 12, "Lower Gastrointestinal Bleeding," Warren Point, M. D.

Gassaway, Braxton Co. Memorial Hospital, 1st Wednesday, 7-9 P. M. — Oct. 5, "Physical Therapy," Louise Christensen, PRT.

Nov. 2, "Update on Nuclear Medicine," Steven Artz, M. D.

Madison, 2nd floor, Lick Creek Social Services Bldg., 2nd Tuesday, 7-9 P. M. — Oct. 11, "Evaluation of Shoulder and Knee Injuries," Tony C. Majestro, M. D.

Nov. 8, "Stress-Related Gastrointestinal Disorders," Warren Point, M. D.

Oak Hill, Oak Hill High School (Oyler Exit, N 19) 4th Tuesday, 7-9 P. M. — Oct. 25, "The Endangered Health Worker: Communicable Diseases," Thomas W. Mou, M. D.

Princeton, Community Hospital Board Room, 4th Thursday, 6:30-8:30 P. M. — "How to Avoid Malpractice," John Haight, J. D.

Welch, Stevens Clinic Hospital, 3rd Wednesday, 12 Noon-2 P. M. — Oct. 19, "Immunization Update, 1983-84," Kathleen V. Previll, M. D.

Nov. 16, "What Other Health Professionals Should Know About Surgery: Pre- and Post-Update," S. Willis Trammell, M. D.

(continued on next page)

Whitesville, Raleigh-Boone Medical Center, 4th Wednesday, 11 A. M.-1 P. M. — Oct. 26, "Management of Chronic Lung Diseases," George L. Zaldivar, M. D.

Williamson, Appalachian Power Auditorium, 1st Thursday, 6:30-8:30 P. M. — Oct. 6, "Appropriate Use of Antibiotics," Richard Parker, M. D., Cafeteria, Appalachian Regional Hospital. (See separate announcement in this issue of *The Journal* for this special program.)

Nov. 3, "Pediatric ENT Problems," Ronald Wilkinson, M. D.

Dec. 1, "OB Emergencies," Louis Sanchez-Ramos, M. D.

Williamson Outreach Program For October Special

A special program on the "Appropriate Use of Antibiotics" will be presented on October 6 for the Williamson Continuing Education Outreach Program from West Virginia University Medical Center/Charleston Division.

The site will be Appalachian Regional Hospital, South Williamson, Kentucky, from 6:30 to 8:30 P. M.

The keynote presenter will be Richard Parker, M. D., Chief, Infectious Diseases Section, Veterans Administration Medical Center, and Associate Professor of Medicine, Howard University School of Medicine, both in Washington, D. C.

(*continued in next column*)

Other sponsors are Appalachian Regional Hospital, Williamson Memorial Hospital and Smith Kline Laboratories.

Health professionals who wish to attend the optional steak dinner should make reservations by October 3 with Ken Muha, RPH, Chairperson, Appalachian Regional Hospital. Telephone (606) 237-5682.

President's Talk, Committees Upcoming In November

There will be two major items to look for in the November issue of *The Journal*.

One will be the Presidential Address delivered by Harry Shannon, M. D., of Parkersburg during the August Annual Meeting of the Medical Association at the Greenbrier.

The other will be the 1983-84 appointments by the current President, Carl R. Adkins, M. D., of Fayetteville, to various Association committees.

In the interest of economics, individual notification of those named to committees will not be provided, although Chairmen will be given Committee rosters and responsibilities.

Association members thus are urged to pay particular attention to the November *Journal* list, and to save it for reference as necessary.

In the left photo, Dr. Frank J. Jirka (left) of the Chicago area, President of the American Medical Association, greets Dr. Frank J. Holroyd of Princeton after addressing the first session of the State Medical Association's House of Delegates during the Association's 116th Annual Meeting August 25-27 in White Sulphur Springs at the Greenbrier. Doctor Holroyd is an Association Delegate to the AMA. On the right, Dr. Harry Shannon of Parkersburg, 1982-83 Association President, prepares for the first House session.

AIDS, Geriatric Pharmacology, Heart Talks Planned

The 17th Mid-Winter Clinical Conference next January 27-29 will include papers on AIDS, geriatric pharmacology, and intracoronary thrombolysis, it was announced by the Program Committee.

The continuing education event, again to be held at the Charleston Marriott Hotel, is sponsored by the State Medical Association and the West Virginia and Marshall University Schools of Medicine.

James N. Frame, M. D.

Other subjects to be discussed during the week-end conference will be children of divorce, flexible sigmoidoscopy, epilespy, Parkinsonism and organic brain syndrome, disability, lumbar intervertebral disc disease, arthritis, and intracoronary thrombolysis, according to Dr. Joseph T. Skaggs of Charleston, Chairman of the Program Committee. Some 18 physician and other speakers will be on the faculty, he added.

Scientific sessions will be held Friday afternoon, Saturday morning and afternoon, and Sunday morning, ending at noon. Following the customary format for the Mid-Winter Clinical Conference, special concurrent sessions for physicians and the public are scheduled Friday evening.

Board of Medicine Update

"West Virginia Board of Medicine Update," an informative presentation on the activities and problems of that Board, has been scheduled for the physicians' session, Doctor Skaggs said.

Help for rape and incest victims, as announced earlier, will be explored during the public session.

The "AIDS" paper, opening both the conference and the Friday afternoon session, will be presented by Dr. James N. Frame, third-year resident, internal medicine, Charleston Area Medical Center and WVU Charleston Division.

Mary Beth Gross, Pharm.D., Assistant Professor of Clinical Pharmacy, WVU Charleston Division, will discuss "Geriatric Pharmacology" during the Saturday morning session.

"Intracoronary Thrombolysis: Clinical Experiences to Date" will be presented Sunday morning by Dr. Joseph F. Hanna, Assistant Professor of Medicine and Director of Invasive Cardiology, MU and Huntington Veterans Administration Medical Center.

Doctor Frame recently was awarded a clinical fellowship in hematological oncology at the Memorial Sloan-Kettering Cancer Center in New York City, beginning July 1, 1984.

He also was accepted for a clinical elective in Coagulation Service at New York University Medical Center in New York City under the auspices of Dr. Robert Silber, beginning this month.

Doctor Frame was born in Morgantown and was graduated from Woodrow Wilson High School in Beckley and West Virginia Wesleyan College. He received his M. D. degree in 1981 from WVU.

Completes Utah Residency

Doctor Gross came to Charleston in June, 1982, after completing a residency in clinical pharmacy (as Chief Resident) at the University of Utah College of Pharmacy in Salt Lake City. In addition to her teaching duties at WVU, Doctor Gross has spoken before numerous professional and community organizations. The latter have included senior citizen groups, with whom Doctor Gross frequently has discussed the proper use of medications.

A registered pharmacist, she is Secretary and Newsletter Editor for the Total Parenteral Nutrition Committee at CAMC, and a member of the Substance Abuse Advisory, Council for Shawnee Hills Community Mental Health/Retardation Center, Inc., in Charleston.

Born in Chicago, she was graduate from Drake University in Des Moines, Iowa, receiving a graduate gerontology certificate and Doctor of Pharmacy degree from the University of Utah. She is the author or co-author of some 20 professional articles.

(continued on next page)

Mary Beth Gross, Pharm.D.

Joseph F. Hanna, M. D.

Doctor Hanna has held his Huntington posts since March, 1982, after completing a fellowship in cardiology at the University of Texas Health Science Center in Houston.

He was graduated in 1976 from St. Joseph University, French Medical School, Beirut, Lebanon; interned at Texas Tech University in Lubbock, and took his residency in internal medicine at Texas Tech University, El Paso.

His research interest is in non-invasive evaluation of the refractory period of accessory pathway in the patient with WPW: comparison of exercise testing and intravenous procainamide.

'Disability Trap' Panel

The disability program, "Into and Out of the Disability Trap," as announced previously, will constitute the Saturday afternoon session. The format will be an in-depth panel discussion, emphasizing audience participation, on the physician and procedures and pitfalls in disability determination. The panel will include an employer's attorney, an attorney familiar with claimants' cases, disability officials from state and federal agencies, and an independent rehabilitation representative.

Dr. Albert F. Heck of Charleston, also as announced previously, will speak on Parkinsonism and Organic Brain Syndrome" during the Saturday morning session.

Other members of the Program Committee are Drs. William O. McMillan, Jr., and C. Carl Tully, both of Charleston; Maurice A. Mufson, Huntington; Robert L. Smith, Morgantown, and Richard G. Starr, Beckley.

The Committee receives continuing assistance from WVU Charleston Division staff members J. Zeb. Wright, Ph.D., Coordinator of Continuing Education, Department of Community Medicine; and Sharon A. Hall, Conference Coordinator.

More information concerning other speakers and subjects will be provided by the Program Committee in upcoming issues of *The Journal.*

Honorary, Retired Members Recognized by Council

The Association's Council, during its pre-Convention meeting in August in White Sulphur Springs, elected the following physicians to dues-exempt honorary membership after similar action by component societies:

Drs. George T. Hoylman of Gassaway, J. C. Huffman of Buckhannon and Thomas M. Snyder, Clarksburg (all members of the Central West

Mrs. Richard S. (Linda) Kerr of Morgantown, 1982-83 President of the Auxiliary to the West Virginia State Medical Association, in the left photo presents a check for $9,706.34 to Dr. Robert W. Coon, Vice President and Dean of Marshall University School of Medicine, during the first House session of the Association's Annual Meeting in August. Mrs. Kerr also presented a check for $15,809.62 to Dr. Richard A. DeVaul (partially seen behind Mrs. Kerr), Dean of the West Virginia University School of Medicine. The checks represent an annual contribution by West Virginia physicians and the Auxiliary to the medical schools through the Education and Research Foundation of the American Medical Association (AMA-ERF). Looking over material prior to the first House session (right photo) are Dr. Harry S. Weeks, Jr. (left), of Wheeling, an Association AMA Delegate, and Dr. John B. Markey of Charleston, 1981-82 Association President, who was elected an Alternate Delegate to the AMA during the Convention.

Virginia Medical Society); J. L. Thompson of Weirton (Hancock); Edwin M. Shepherd, Charleston (Kanawha); the late Joseph D. Romino, Fairmont (Marion); David L. Ealy of Moundsville and David E. Yoho, Glen Dale (Marshall), and J. Paul Champion, Princeton (Mercer).

Dr. Russell A. Salton, Williamson (Mingo) was elected to retired membership; and Dr. James M. Garvey, Weirton (Hancock) was granted a one-year dues waiver due to disability.

Annual Elections Conducted By Sections, Societies

Here are officers elected or re-elected by specialty societies or sections during meetings in conjunction with the West Virginia State Medical Association's Annual Meeting in August at the Greenbrier:

West Virginia State Society of Anesthesiolologists: Drs. Jeanne A. Rodman, Morgantown, President; Josiah K. Lilly III, Charleston, Vice President, and David F. Graf, Morgantown, Secretary.

West Virginia Radiological Society: Drs. Johnsey L. Leef, Jr., Charleston, President; John C. Turner, Fairmont, Vice President; and William G. Hayes II, Charleston, Secretary-Treasurer.

Section on Orthopedic Surgery: Drs. J. David Blaha, Morgantown, President; Stephen I. Lester, Elkins, Vice President; and George Orphanos, Beckley, Secretary-Treasurer.

Review A Book

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication.

Review of Medical Physiology, 11th Edition, by William F. Ganong, M. D. 643 pages. Price $20. Lange Medical Publications, Los Altos, California 94022. 1983.

Handbook of Pediatrics, 14th Edition, by Henry K. Silver, M. D.; C. Henry Kempe, M. D.; and Henry B. Bruyn, M. D. 883 pages. Price $13. Lange Medical Publications, Los Altos, California 94022. 1983.

Handbook of Poisoning, 11th Edition, by Robert H. Dreisbach, M. D. 632 pages. Price $11. Lange Medical Publications, Los Altos, California 94022. 1983.

Current Surgical Diagnosis and Treatment, 6th Edition, by Lawrence W. Way, M. D. 1,221 pages. Price $28. Lange Medical Publications, Los Altos, California 94022. 1983.

In the left photo, Dr. Samuel P. Asper (left), President of the Educational Commission for Foreign Medical Graduates in Philadelphia and Professor of Medicine, The Johns Hopkins University, is shown with Dr. Roland J. Weisser of Morgantown, a member of the 1983 Annual Meeting Program Committee. Doctor Asper gave the keynote address during opening exercises of the State Medical Association's convention in August. On the right, some of the speakers for the first general scientific session on sexually transmitted diseases are shown with Dr. David Z. Morgan (center) of Morgantown, Chairman of the Program Committee. They are Drs. Edmund C. Tramont, M. D. (left) of Washington, D. C., and Jack L. Summers, of Akron, Ohio.

Mrs. T. Keith Edwards Installed As Auxiliary President

Mrs. T. Keith Edwards of Bluefield assumed the presidency of the Auxiliary to the West Virginia State Medical Association at the group's 59th Annual Meeting at the Greenbrier in White Sulphur Springs, August 25-27.

Mrs. Edwards was installed by Mrs. John G. Bates of Cuthbert, Georgia, President of the Auxiliary to the American Medical Association, who was an honor guest.

Mrs. T. Keith Edwards

The Auxiliary elected Mrs. Harry S. Weeks, Jr., of Wheeling as President Elect and the following additional officers:

Mrs. Charles C. Weise, Charleston, Vice President; Mrs. Herman Fischer, Bridgeport, Recording Secretary; Mrs. Edward M. Spencer, Bluefield, Corresponding Secretary; Mrs. Harvey D. Reisenweber, Martinsburg, Treasurer; Mrs. J. L. Mangus, Charleston, Parliamentarian;

Mrs. M. V. Kalaycioglu, Shinnston, Northern Regional Director; Mrs. L. Walter Fix, Martinsburg, Eastern Regional Director; Mrs. Grady McRae, Bluefield, Southern Regional Director; Mrs. William J. Echols, Huntington, Western Regional Director; Mrs. Jose M. Serrato, South Charleston, Central Regional Director, and Mrs. Richard S. Kerr, Morgantown, Past President on Board.

Committee Chairmen

Mrs. Edwards also announced these appointments of committee chairmen, or co-chairmen:

Mrs. Antonio S. Licata, Weirton, and Mrs. Robert S. Strauch, Martinsburg, AMA-ERF; Mrs. Robert S. Robbins and Mrs. John W. Kennard, both of Wheeling, Health Projects; Mrs. Richard S. Kerr, Morgantown, and Mrs. Gary G. Gilbert, Huntington, Long Range Planning; Mrs. Harry Shannon, Parkersburg, Legislation; Mrs. Harry S. Weeks, Jr., Wheeling, Membership; Mrs. Charles E. Turner, Huntington, Bylaws and Handbook; Mrs. Tony C. Majestro, Charleston, Historian;

Mrs. Hossein Sakhai, Huntington, Members At Large; Mrs. Harry S. Weeks, Jr., Wheeling, WESPAC; Mrs. Logan W. Hovis, Vienna, Convention; Mrs. George Naymick, Newell; Mrs. Logan W. Hovis, Vienna, and Mrs. Carlos F. DeLara, Logan, Health Careers Loan Fund; Mrs. Winfield C. John, Huntington, Southern Medical Councilor; Mrs. George A. Curry, Morgantown, Southern Medical Vice Councilor;

Mrs. Edward M. Spencer, Bluefield, Press and Publicity Scrapbook; Mrs. Thomas W. Crosby, Morgantown, Liaison to Physicians Service Committee; Mrs. George A. Shawkey, Charleston, Necrology; Mrs. W. M. Jennings, Huntington, RPMS Spouse Liaison; Mrs. M. V. Kalaycioglu, Shinnston, Shape Up For Life; Mrs. John D. Richmond, Beckley, News Bulletin Editor, and Mrs. Davis C. Foster, Beckley, Circulation Manager.

Mrs. Edwards (Alice) was born in Union Mills, North Carolina, a rural community in the foothills of the Blue Ridge Mountains. She graduated from the Rutherford Hospital School of Nursing and attended the University of South Carolina. She and her husband, an obstetrician-gynecologist, served as medical missionaries in Nigeria, West Africa, for 10 years.

Since coming to West Virginia in 1970, Mrs. Edwards has taken the examination necessary for certification as a Registered Nurse Practitioner in Obstetrics and Gynecology, and has been certified as a Physician's Assistant. She works with her husband. In addition, she is a partner and

Shown above are some of the new officers of the Auxiliary to the State Medical Association elected during the Auxiliary's annual meeting in August. Seated, from left, are Mrs. Harry S. Weeks, Jr., Wheeling, President Elect; Mrs. T. Keith Edwards, Bluefield, President, and Mrs. Harvey D. Reisenweber, Martinsburg, Treasurer; standing, from left, Mrs. Jose M. Serrato, South Charleston, Central Regional Director; Mrs. Herman Fischer, Bridgeport, Recording Secretary; Mrs. Charles C. Weise, Charleston, Vice President; Mrs. L. Walter Fix, Martinsburg, Eastern Regional Director, and Mrs. M. V. Kalaycioglu, Shinnston, Northern Regional Director.

buyer for "The Nesting Place," a family-owned maternity shop with stores in Bluefield and Kannapolis, North Carolina.

Mrs. Edwards has been active in the Auxiliary since 1970, and is a Past President of the Mercer County Auxiliary.

The Edwards have one son, Benjamin, of Bluefield, and three daughters, Alisa Smith of Durham, North Carolina; Harriet Michael of Louisville, Kentucky, and Marianne Phillips of Jonesboro, Tennessee.

Workload Increases Committee, Council, House Burden

In what amounted to marathon sessions, the Medical Association's Executive Committee and Council dealt with perhaps an unprecedented amount of business at pre-convention and other meetings in August.

The Executive Committee met in Charleston on August 6-7, prior to its usual meeting in advance of the Council session at the Greenbrier. Here is a summary of major actions taken by the Executive Committee, Council and—where necessary—by the House of Delegates:

—Approved a new salary and job classification plan for the Association's headquarters staff, with provisions for a Deputy Executive Secretary.

—Received an invitation from the Greenbrier to return for the 117th Annual Meeting August 23-25, 1984—but directed a detailed study of the feasibility of alternate sites and/or dates for future years in line with expressions received from members during a recent survey.

—Approved work with West Virginia University and Marshall University Schools of Medicine toward co-sponsorship of the Annual Meeting scientific program and Category 1 continuing medical education credit.

—Tabled, pending development of the 1984 calendar and fiscal-year Association operating budget, Committee on Medical Scholarships recommendations for increasing the monetary amount of Association scholarships for state medical school students.

BIC Membership Approved

—Voted to become a member of the West Virginia Business and Industrial Council (BIC), the state business community's major legislative lobbying group.

—Approved steps to affiliate with other southeastern states making up a regional caucus group within the general American Medical Association structure.

—Voted to recommend to the appropriate American Medical Association Council and House of Delegates that third parties change

In the left photo, Dr. Carl R. Adkins of Fayetteville, who was installed as President during the State Medical Association's Annual Meeting, is shown with his wife, Susan, and son, Jonathan. The Association's Publication Committee (right photo) met during the convention. Seated, from left, are Drs. David Z. Morgan, Morgantown, Associate Editor of The West Virginia Medical Journal; Stephen D. Ward, Wheeling, Editor, and L. Walter Fix, Martinsburg, Associate Editor; standing, from left, Drs. Thomas J. Holbrook, Huntington; John M. Hartman, Charleston, and Joe N. Jarrett, Oak Hill, Associate Editors. Not shown is Dr. Vernon E. Duckwall, Elkins, Associate Editor.

to an indemnity system of reimbursement for physicians' services.

—Urged continued efforts in the state legislative arena toward so-called tort reform in relation to professional liability insurance coverage and related matters.

—Provided conditional approval for a group of physicians practicing in Putnam County to continue work toward establishing a new component society in that area (the component would be the 30th affiliated with the Medical Association).

—Elected (in Council action) Ralph W. Ryan, M. D., of Morgantown as the nucleus member of the West Virginia Medical Political Action Committee (WESPAC) Board in the Second Congressional District.

Aetna Dividend Status

—Heard a report of continued correspondence with the Aetna Life and Casualty Company in efforts to obtain information related to dividend features of the Association-endorsed liability insurance program for which Aetna was the carrier from December, 1972, through 1980.

—Received (in Executive Committee and Council meetings) a detailed update of the Association's currently endorsed program with CNA of Chicago as the carrier.

—Reviewed the Association's financial statement of receipts and expenditures for January through June, along with membership trends generally consistent with those of a year earlier.

—Heard a general summary of recent membership surveys, with the Executive Committee being advised that results would be summarized in various ways in upcoming issues of *The West Virginia Medical Journal.*

Residents' Dues

—Approved (by Council action) a process for residents to pay State Medical Association dues direct to the state office.

Heard annual report covering program developments, etc., from heads of state human services, insurance, health vocational rehabilitation and workers' compensation agencies, along with Nationwide Insurance, the Part B carrier for Medicare in West Virginia.

Other action taken during the Annual Meeting on such matters as election of honorary members, resolutions adopted and the approval of Constitution and Bylaws amendments are covered elsewhere in this issue of *The Journal.*

New President Proposes Strategy for Change

The West Virginia State Medical Association is in a "process of transition and must continue that process if we are to serve our membership," Carl R. Adkins, M. D., of Fayetteville emphasized after taking his oath as the organization's 1983-84 President.

"In fact," he told the House of Delegates during the Annual Meeting at the Greenbrier, "the survival of this organization depends much upon our course of action during the next several years."

"We must be innovative in our thinking and must structure our organization so that we are planning our strategy instead of reacting to isolated changes in the environment and health care systems," Doctor Adkins added.

He said that "perhaps my most important role during the next year will be to serve as a catalyst as these various changes are discussed. And together we must plan a strategy for change."

Doctor Adkins made reference to findings of a recent membership survey, and noted the need for improvement indicated in several areas, including communications with the public, legislative activities and dealing with such problems as government regulations and the cost of medical care.

Recognizing certain limitations anti-trust and other statutes might impose, Doctor Adkins said that "we can no longer allow a few unethical physicians charging outrageous fees to taint the entire medical profession. We must assume an active role in developing a program to address these problems."

Marshall Honors Five Medical Students

Five state students were honored in September during opening exercises for the Marshall University School of Medicine.

Susan A. Terry of Weirton received the Year III Achievement Award. A registered nurse since 1970, she completed a Bachelor of Science degree in nursing at West Liberty State College, where she graduated with highest honors in 1979.

Kevin W. Yingling of Huntington received the Year II Achievement Award. He graduated first

in his class from the West Virginia University School of Pharmacy in 1981, and was the 1981-82 Year I Achievement Award winner. He is a Barboursville High School graduate.

Vienna native Stevan J. Milhoan received this year's Year I Achievement Award. Milhoan, a 1980 magna cum laude pharmacy graduate of WVU, is a graduate of Parkersburg High School.

Scott Henson of Hurricane and Joedy Daristotle of Fairmont, both incoming juniors, received Pathology Department awards. Henson attended West Virginia Institute of Technology, where he played varsity basketball. Daristotle is a biology graduate of WVU.

The incoming School of Medicine seniors named Dr. Joyce Martin of Barboursville as outstanding clinical instructor, and Dr. Michael Kilkenny of Union as the best resident instructor.

Medical Program Payments Get Back on Schedule

A speed-up in money available has enabled the West Virginia Department of Human Services to process backlogged medical services claims and once again get on a current basis.

Assistant Commissioner David W. Forinash advised *The Journal* on September 13 that "we are now processing all the backlogged claims. Also, we are now processing all medical claims on a current basis. That means that any 'clean claim' which does not pend for special review or have an error in its preparation will be processed in approximately 20 days."

The Journal reported in September that the state's money problems and a monthly pattern of allocations to the Department of Human Services were causing some delays in paying for medical program services provided by physicians and others.

Mr. Forinash said, however, that as of mid-September money was being made available to the Department "in larger proportions than initially planned," and as a result reimbursement was moving back on schedule.

"I think this is an indication of the Department's interest and ability, when adequate resources are available, to be responsive to billings submitted by medical providers," he said.

"I know that you (the Medical Association) have realized this and have acknowledged it several times in the past. For that fairness and support, we are appreciative. . . . "

Medical Meetings

Oct. 2-5—Am. Neurological Assoc., New Orleans.

Oct. 5-8—Am. Thyroid Assoc., New Orleans.

Oct. 7-8—AMA Congress on Occupational Health, Beachwood, OH.

Oct. 16-21—Am. College of Surgeons, Atlanta.

Oct. 20-22 — Educational Skills (MU Medical School), Huntington.

Oct. 22-27—Am. Academy of Pediatrics, San Francisco.

Oct. 23-26—Am. College of Gastroenterology, Los Angeles.

Oct. 23-27—Am. College of Chest Physicians, Chicago.

Oct. 24-27—Am. College of Emergency Physicians, Atlanta.

Oct. 26-30—Am. Academy of Child Psychiatry, San Francisco.

Oct. 30-Nov. 3 — Am. Academy of Ophthalmology, Chicago.

Nov. 6-9—Scientific Assembly, Southern Medical Assoc., Baltimore.

Nov. 7-9—Am. Medical Women's Assoc., Dearborn, MI.

Dec. 3-6 — Am. Society of Hematology, San Francisco.

Dec. 4-7 — Interim Meeting, AMA House, Los Angeles.

1984

Jan. 19-21—Neurosurgical Society of the Virginias, Williamsburg, VA.

Jan. 27-29—17th Mid-Winter Clinical Conference, Charleston.

Feb. 9-14—Am. Academy of Orthopaedic Surgeons, Atlanta.

Feb. 12-15—W. Va. Perinatal Assoc., Snowshoe.

Feb. 15-19—Am. College of Nuclear Physicians.

March 17—Annual Meeting, W. Va. Affiliate, American Diabetes Assoc., Wheeling.

March 25-29—Am. College of Cardiology, Dallas.

April 6-8—WV Chapter, AAFP, Charleston.

April 9-13—Am. Roentgen Ray Society, Las Vegas.

May 2-5—W. Va. Chapter, Am. College of Surgeons; and W. Va. Otolaryngological Society, White Sulphur Springs.

May 7-9 — Am. Assoc. for Thoracic Surgery, New York City.

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WVU Medical Center
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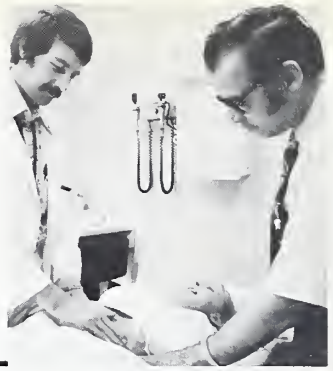

Compiled from material furnished by the Medical Center News Service, Morgantown, W. Va.

Pump Implantation Used For Liver Cancer

Keeping up with the latest techniques for the treatment of malignancies, WVU Hospital has achieved another first in the state with the implantation of a pump to deliver chemotherapy to a liver cancer patient.

Infusion of chemotherapy into the arteries supplying blood to tumor sites is a concept which has been tried with varying degrees of success over the past 20 years. Problems with catheters and required hospitalization, or the necessity for the patient to wear a bulky harness for an external pump, limited use of prior perfusion techniques.

The implantable pump is an attempt to minimize these problems. Following surgical placement, it permits patients to receive chemotherapy on an outpatient basis.

Normal Activities Possible

Patients are able to continue their normal activities while receiving continuous infusion. They are cautioned, however, against physical stress to the tissues adjoining the implant site.

Fever or travel to high elevation calls for consultation with a physician, since changes in body temperature and external air pressure can affect the rate of perfusion.

Leland J. Foshag, M. D., Assistant Professor of Surgery, has performed the implantation in one patient, and others are being evaluated as possible candidates.

Doctor Foshag, Dr. Alvin Watne, Professor and Chairman of Surgery, and Dr. Frederick Avis, Assistant Professor and Surgical Oncologist, are those most directly involved with the procedure at the Medical Center.

"Intraarterial infusion chemotherapy with the implantable pump is basically designed for patients with liver cancer—either primary carcinoma or metastases from colon or rectal cancer," Doctor Foshag explained.

He said the presence of systemic disease would rule out hepatic artery infusion.

"If the patient has bone or lung metastases, you would not put the pump in simply for the liver," he explained.

"If the metastases are localized to portions of the liver you can sometimes resect them, with an increase in survival as well. In effect, we're limiting placement of the pump to patients who have involvement in both lobes of the liver where surgery would not be possible."

Survival Extended

Results of clinical trials at other centers have indicated an 85-per cent response rate, according to Doctor Foshag. "Basically, this means that the metastases have decreased in size and usually in number with improvement in general condition of the patient.

"These studies have shown that the survival rate has been extended from as little as four to six months up to what seems to be a maximum of 24 months," he said.

The pump is a titanium disk about the size and shape of a small hockey puck. It has two chambers. One holds the medication. The other is permanently sealed and contains the fluorocarbon power source.

It is implanted in a pocket under the skin of the abdomen, usually below the belt line.

Correction

Dr. Howard H. Kaufman, in a story on Page xviii (WVU Page) of the September issue of *The Journal*, should have been identified by *The Journal* as WVU Associate Chairman of Neurosurgery instead of Chairman of Neurosurgery. Dr. G. Robert Nugent is Chairman of Neurosurgery. *The Journal* regrets this error.

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Third-Party News, Views and Program Concerns

Licensure Ultimate Goal For Rehab Center

The State Division of Vocational Rehabilitation has as an ultimate goal the licensure of its center at Institute, near Charleston, as a skilled nursing facility or a level-two physical rehabilitation unit.

Division Director Earl Wolfe told the State Medical Association Council during an August meeting in White Sulphur Springs that such licensure "would enable us to capture third-party funds from the Veterans Administration, Workers' Compensation, private insurance (carriers) and other sources." Mr. Wolfe continued:

"We have as our goal making the center as fiscally independent of the state appropriation process as we can make it. Certainly we would like to see third-party funding reach the same level at the center as it does at the Woodrow Wilson Rehabilitation Center in Virginia.

State Funds Needed

"We hope the Legislature will see the wisdom of our plans and can somehow find the funds necessary for such a move. It will save the State of West Virginia money in the long run."

Mr. Wolfe noted that the Institute center was accredited last year by the Commission on Accreditation of Rehabilitation Facilities, and that "this year, we have put into operation the new medical clinic which consolidates into one modern, well-equipped area all the medical aspects of our services to severely disabled persons."

Budget problems continue to handicap the rehabilitation program, although Mr. Wolfe said the Division rehabilitated in the fiscal year ended June 30 a total of 4,146 disabled West Virginians into gainful employment, an increase of 608 over the fiscal 1982 figure.

Severely Disabled Included

"I'm all the more delighted because 46 per cent of those rehabilitated individuals are classified as severely disabled, clients who required significant investments of time and money to get them back to work," he reported.

"As we did last year," the rehabilitation director continued, "our appropriation request for fiscal 1985 seeks a significant increase in state funding, almost a 33-per cent increase over the $8.9-million appropriation we have this year."

Requested Increase Doubtful

"However, unless the state's revenue picture improves markedly by next July, it's extremely doubtful that we can get anywhere near that amount of increase. And we can't look for much more in federal funds, about a three-per cent increase at the most," he said.

"I want you to understand that we will increase our medical fees just as soon as we can, but any immediate relief doesn't appear to be in the offing. I want you also to know that we appreciate your willingness to sacrifice your income to help us help disabled persons," Mr. Wolfe emphasized.

New HHS Regulations Impose False Claim Penalties

New regulations, effective in September, penalize physicians, hospitals and other health care providers who file false Medicare and Medicaid claims.

The regulations permit the U. S. Department of Health and Human Services to suspend providers who file false or improper claims from participation in Medicare and Medicaid. In addition, HHS may impose assessment of up to twice the amount of the improper claim and add certain other penalties.

DRG Regulations Available

The U. S. Department of Health and Human Services has released 140 pages of interim regulations and comments related to prospective payments/diagnostic related groups (DRGs) for Medicare inpatient services.

Copies may be obtained by contacting the State Medical Association's Staff Counsel, Robert F. Bible.

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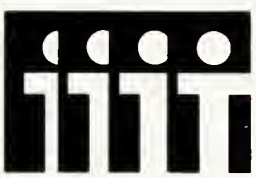

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Obituaries

CHARLES P. S. FORD, M. D.

Dr. Charles P. S. Ford of Huntington died on September 8 in a hospital there. He was 91.

Born in Fayette County, he received his M. D. degree in 1917 from the Medical College of Virginia. He was a former member of the State Medical Association.

He was a former member of the State Medical Association.

Survivors include the widow; one daughter, Mrs. George Heiner of Birmingham, Alabama; and one son, Charles W. Ford of West Chester, Pennsylvania.

* * *

MARION F. JARRETT, M. D.

Dr. Marion F. Jarrett, Charleston internist, died on September 12 in a hospital there. He was 70.

A former Chief of Staff at St. Francis Hospital in Charleston, he had practiced in Charleston since 1946.

Doctor Jarrett, a native of Charleston, was graduated from Hampden-Sydney College and West Virginia University, and received his M. D. degree in 1939 from the Medical College of Virginia.

He completed his internship and residency at St. Luke's Hospital in Cleveland.

Doctor Jarrett served in the U. S. Army Medical Corps during World War II.

He was a member of the American Society of Internal Medicine, and an honorary member of the Kanawha Medical Society, West Virginia State Medical Association and American Medical Association.

Survivors include the widow; two daughters, Mrs. Myrna J. Ives of Oakton, Virginia, and Jean F. Jarrett of Vienna, Virginia; a son, Thomas M. Jarrett of Richmond, Virginia; two sisters, Mrs. James A. Price of Charleston and Mrs. Harold G. Walker of Dunbar, and a brother, Homer C. Jarrett, Jr., D. D. S., of Charleston.

* * *

WARREN D. LESLIE, M. D.

Dr. Warren D. Leslie, Wheeling pediatrician, died on August 19 in a Wheeling hospital. He was 65.

Doctor Leslie, former Chief of Pediatrics at Ohio Valley Medical Center in Wheeling, retired from private practice in 1979, but had continued working with the Wheeling Health Department until the time of his death.

Born in Uniontown, Pennsylvania, he was graduated from West Virginia University, and received his M. D. degree in 1943 from Jefferson Medical College. He interned at Uniontown (Pennsylvania) Hospital, and completed pediatric residencies at Detroit Children's Hospital and Columbus Children's Hospital.

Doctor Leslie, who served as a captain in the U. S. Army Medical Corps, was a Fellow of the American Academy of Pediatrics, and a member of the Academy's West Virginia Chapter, the Ohio County Medical Society and West Virginia State Medical Association.

Survivors include the mother, Mrs. Bertha Mae Leslie of Wheeling; the widow; one daughter, Eleanor Taylor of Wheeling, and one son, John P. Leslie II of Wheeling.

* * *

JOSEPH D. ROMINO, M. D.

Dr. Joseph D. Romino, Fairmont surgeon, died on August 13 in a hospital there. He was 74.

A native of Fairmont, Doctor Romino was Chief of Surgery at Fairmont General Hospital for almost 30 years.

He was graduated from West Virginia University, and received his M. D. degree in 1935 from Rush Medical School of the University of Chicago. He interned at St. Mary's Hospital in Detroit.

Doctor Romino then returned to Fairmont and accepted a preceptorship with the late Dr. Chesney Ramage, with whom he was associated for 12 years.

Certified by the American Board of Abdominal Surgeons, he also was on the surgical and medical staffs of Fairmont Emergency Hospital and Grafton City Hospital.

Doctor Romino was an honorary member of the Marion County Medical Society, West Virginia State Medical Association and American Medical Association; a member of the American Society of Abdominal Surgeons, and a Fellow of the International College of Surgeons.

He served on the State Medical Association's Legislative Committee for many years.

Survivors include the widow; two daughters, Beverly Ann Jeziori and Donna Jo Metz, both of Fairmont; one son, Joseph D. Romino, Jr., of Orange Park, Florida; two brothers, Dominick J. Romino and Antony Romino, both of Fairmont, and two sisters, Mrs. Veto Piscitelli of Fairmont and Mrs. Ray Greco of Weirton.

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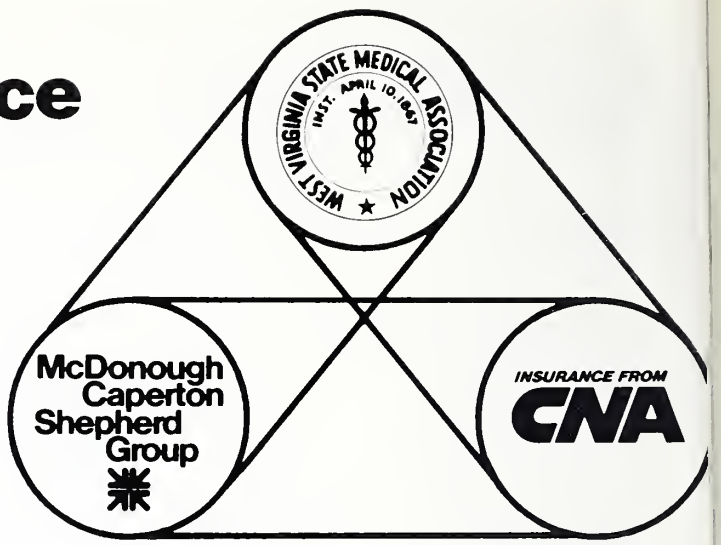

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Necrology Report

The following is a list of West Virginia physicians whose deaths have been reported to the West Virginia State Medical Association during the past year:

1982

Aug.	5—George S. Appleby	Martinsburg
Aug.	23—Donald N. Ball	Princeton
Sept.	16—Olin C. Glass	Sissonville
Sept.	22—E. Hunter Boggs	Charleston
Oct.	2—Kenneth J. Hamrick	Maxwelton
Oct.	6—Clyde A. Harper	Zephyrhills, Florida
Oct.	8—Arthur E. Glover	Madison
Nov.	17—Kenneth E. Blundon	Eugene, Oregon
Nov.	30—Clark K. Sleeth	Morgantown
Dec.	4—Bernard Zimmermann	Morgantown
Dec.	7—Thomas G. Reed	Charleston
Dec.	16—A. C. Woofter	Parkersburg

1983

Jan.	2—Siegfried Werthammer	Sarasota, Florida
Jan.	7—Richard W. Wingfield	Keller, Virginia
Feb.	9—Max O. Oates	Martinsburg
Feb.	11—John C. Godlove	Martinsburg
Feb.	13—Leo H. T. Bernstein	Martinsburg
Feb.	19—Peter D. Crynock	Morgantown
Feb.	20—Daniel N. Barber	Charleston
Mar.	5—James E. Wotring	Fairview
Mar.	19—James H. Thornbury	Belle
Mar.	21—Thomas V. Shiels	South Charleston
Apr.	2—Sanga Tanlulavanich	Welch
Apr.	4—William E. Anderson	Cumberland, Maryland
Apr.	21—Enoch W. White, Jr.	Red Jacket
May	3—Spencer L. Bivens	Charleston
May	31—V. R. Anumolu	Fairmont
May	31—Sam Milchin	Bluefield, Virginia
July	13—Harold B. Ashworth	Glen Dale
July	26—Raymond W. Cronlund	Philippi
July	28—Pedro L. Casingal	Oak Hill
Aug.	13—Joseph D. Romino	Fairmont

Respectfully submitted,
CHARLES R. LEWIS
Executive Secretary

Charleston, WV
August 25, 1983.

Note: On December 16, 1982, staff at State Medical was notified of the death of Dr. W. R. Yeager of Parkersburg, who expired on July 17, 1981.

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Resolutions

The following resolutions were adopted by the House of Delegates during the August 25-27 Annual Meeting of the West Virginia State Medical Association at the Greenbrier in White Sulphur Springs.

A substitute for Resolution No. 1, presented by Council and dealing with the state's Air MEDEVAC Program, reads as follows:

"WHEREAS, There has always been in West Virginia a real need to provide a rapid, safe method of transporting critically ill or injured citizens from rural general medical facilities to specialty care centers; and

WHEREAS, Using existing limited manpower and equipment resources on a "pilot project" basis, the West Virginia State Police have for the past year addressed this problem with an Air MEDEVAC program properly coordinated through the state's Emergency Medical Service System; and

WHEREAS, This limited effort has during its duration contributed to the saving of a significant number of lives by overcoming the time and distance barriers of our rugged terrain; and

WHEREAS, Operation of the Air MEDEVAC "pilot project" has clearly demonstrated the medical need for this vital link in West Virginia's Emergency Medical Service System; and

WHEREAS, The development of the State Police Air MEDEVAC program, adequately manned and equipped with aircraft to allow response on a twenty-four hour statewide basis, is recognized as a service which the State of West Virginia can provide which not only will save lives, but also will make a significant contribution to the containment of health care costs through the effective utilization of scarce specialty care center resources;

THEREFORE, BE IT RESOLVED, That the West Virginia State Medical Association hereby commend Governor John D. Rockefeller IV and his Department of Health and Public Safety for their initiative in directly addressing the long-standing need for an Air MEDEVAC program in West Virginia; and

BE IT FURTHER RESOLVED, That the West Virginia State Medical Association urgently request Governor John D. Rockefeller IV to consider funding necessary for the rapid development of the State Police Air MEDEVAC program, inclusive of additional personnel and acquisition of essential and appropriate aircraft, as a matter of high priority in the presentment of his Executive Budget to the 1984 Session of the West Virginia Legislature."

Adopted was the following substitute for Resolution No. 2, presented by the Greenbrier Valley Medical Society and dealing with licensure of physicians in West Virginia:

"BE IT RESOLVED, That the West Virginia State Medical Association endorse the concept of an identical qualifying examination for doctors of medicine and osteopathy for licensure to practice in West Virginia."

CHANGE OF ADDRESS

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. The 1984 Roster of Members will be prepared and placed in the mails shortly after the first of the year and we would very much like for your correct address to appear in same. If applicable, to comply with recent U. S. Postal Service regulations, please include your P. O. Box number with zip code. Changes should be mailed to Box 1031, Charleston, West Virginia 25324.

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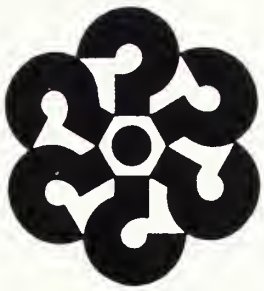

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The West Virginia Medical Journal

VOL. 79, NO. 11 NOVEMBER, 1983

Presidential Address*

HARRY SHANNON, M. D.
Parkersburg, Immediate Past President, West Virginia State Medical Association

THIS appearance brings down the curtain on my year as President of your organization. This has been a fantastic year, a busy year, a chaotic and sometimes frustrating year. I am amazed to find that it has gone so swiftly, but its memories will not fade. In my farewell appearance before you, I would like to share some of my thoughts, impressions and recommendations for the future.

First, I would like to thank those that made this such a wonderful year, and this means You, the Members of the Association. Wherever Judy and I went, we were warmly greeted and made to feel at home and appreciated. We have made many new friends, and for this I want to thank each one of you in the Association.

Next, I would like to thank my wife, Judy. Even though she could not be with me on all my visits because of her time commitments and those of our three small boys, she was unfailing in her support and encouragement for my activities. If the babysitter fell through unexpectedly or a household complication developed, she was always able to handle it and take care of getting me to where I needed to be. Without her, I could not possibly have done it. Thank you, dear.

Next, I would like to thank our headquarters office staff: Charlie, Custer, Bob, Mary, Sue, Mary Sue, and most recently, Candy. Without their enthusiastic help, information and experience, this would have been an impossible task. To misquote Winston Churchill, "Never have so few done so much for so many." They deserve and get my warmest thanks and appreciation.

When I started this year, one of my concerns was communication. I have tried to make this a theme for this year and have been very gratified by its acceptance. I feel we have had improvement in communication in all levels this year, and I am pleased by this. My impression is, however, that although we have begun to solve some of our problems, many others still await us.

Harry Shannon, M. D.

Presented at the second and final session of the House of Delegates, 116th Annual Meeting of the West Virginia State Medical Association, the Greenbrier, White Sulphur Springs, W. Va., Saturday, August 27, 1983.

We did not do as well in the legislative area in 1983 as I had hoped; and with the current make-up of the Legislature I think we can continue to expect problems there. We need to persist in our efforts, though, and not give up just because the problem may be difficult. I would recommend that our legislative committee increase its activities and consider development of a key-man approach to contact the legislators at times other than in the heat of the legislative session.

I would recommend to you, the Membership, and especially as Delegates to this House that if the Association office or one of the legislative committee calls you about a particular piece of legislation or a legislator, you make every effort to accept *your* responsibility for action. More and more, the way we practice Medicine is determined not in our offices but in the halls of the Legislature. The changes in the practice of Medicine as we have known it are coming about through the Legislature, at the state and national levels. If we have no input into this process, the quality of care and the welfare of our patients obviously will suffer.

The True Image

In the same vein, our public relations activities must continue and be improved. In my travels throughout our state and our neighboring states on your behalf, I have been astounded at the amount of good being done by physicians at all levels. I am amazed and somewhat disappointed by the lack of public knowledge and appreciation of these efforts. I would recommend that our Public Service Committee be revitalized and possibly expanded in order to put across the true image of the physician as healer to the public, and to counter some of the biased and slanted reporting from some of the more irresponsible members of the media. Of course, bad news sells papers, but I certainly feel there is space for some good news as well. The difficulty is getting it publicized. I have been impressed that, more and more, physicians are abandoning their traditional low profile, and *are* speaking up on matters of community interest and health care. This is a trend that we need to encourage in every way possible.

Last year, I invited the foreign medical graduates in our Association to become more involved, and through this year I have been very happy to see their increasing involvement, especially at the local and county levels. We must have this involvement continue on the state level as well.

There have been many different and difficult challenges for our organization to meet during this past year. There will be even more in future years. I am happy to report that our organization is in excellent shape to respond to these challenges. During one of the most difficult economic periods of our state's history, we have maintained our membership, and our organization is on a fiscally and financially sound basis. There are improvements that need to be made, of course.

Accomplishments

Membership is the life blood of our Association, and we each need to take the responsibility of recruiting at least one of the physicians who are now not members. This must be accomplished if we are to speak as a unified voice for Medicine in our state. During the past year many improvements have been made that strengthen our Association's ability to meet future challenges. Dr. Carl Adkins' committee on staff classification and internal affairs has done yeoman work on staff organization, and we all owe them a debt of gratitude for putting this part of our Association on a business-like basis. The new position of Deputy Executive Secretary which you have approved is an example of this organizational work. Under the direction of Dr. John Markey, plans are going ahead with the proposed building to house our organization, and I feel confident this will be a tremendous asset in the future. A committee under the leadership of Dr. Roland "Bud" Weisser is establishing a firm base for our ongoing risk management and quality assurance activities. You will hear more about this in the near future. Our Insurance Committee under Dr. Jack Leckie has continued its close cooperation and evaluation of our endorsed professional liability plan. Of course, malpractice insurance will always be expensive, as well as necessary, but at least now we are able to talk to our insurance carrier directly and be judged more on the basis of our West Virginia experience. We also have made progress in the establishment of a medical students' section and residents' section of our Association, in order that these future doctors may join with us and participate in our deliberations for the care of their future patients as well as ours.

Recommendations

I would recommend during the next year that our Constitution and Bylaws Committee be charged with the task of reevaluating and revamping our Constitution in light of today's needs to strengthen further and refine our organization, and report its recommendations back to this House next year. I also would recommend that our Committee on Long Range Planning become more active to prepare the

Association for future challenges. There is no doubt there will be many of them. Such things as changes in reimbursement mechanisms based on DRGs, preferred provider organizations, HMOs and IPAs and increased competition from hospitals and free-standing care facilities in the health field are but a few of the future changes our organization must be prepared for, and I am confident it will, through the efforts of my successor, Doctor Adkins, and with the actions and support from you, the membership.

In conclusion, I would like to thank you for the opportunity of serving as your President. This has been a high point of my life. I appreciate the confidence you have shown in me and have done my best to be worthy of that trust. I will be happy to continue to serve in any capacity under the capable leadership of Dr. Carl Adkins, for I know you will support him as you have supported me. In closing, I would remind you of the saying that, "In order for evil to triumph, all that is necessary is for men of good will to do nothing." Let it *not be said* of this Association that we were content to do nothing! I thank you, and God bless you.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (no onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing the most commonly known trade-name drug of that designation. In addition, a listing of all generic drugs mentioned in the article, with their trade-name equivalents, should appear at the end of the article.

A short abstract summarizing the manuscript should be included. This should be typed in double space on a separate page.

Authors are requested to submit a carbon copy with the original.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for reproduction should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. Cost of printing black and white photos in excess of 4 will be billed to author, and no more than 25 references will be published free of charge to the author. A legend should be provided for each illustration and, preferably, attached to it.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

Home Monitoring Of Infants In West Virginia: A Clinician's Viewpoint

DAVID Z. MYERBERG, M. D.
Associate Professor of Pediatrics, West Virginia University Medical Center, Morgantown

DENNIS L. BURECH, M. D.
Wheeling, West Virginia; Clinical Associate Professor of Pediatrics, West Virginia University

APNEA and heart rate monitoring of infants can be performed at home. This practice is quite common in West Virginia as well as in the rest of the eastern United States.[1-9] Monitoring is prescribed by physicians who have a genuine concern that the infant under surveillance may have a life-threatening event. The final common pathway of this event is apnea and/or bradycardia, and the physician's hope is that the monitor will warn the parents in time for successful resuscitation.

Two issues about home monitoring merit discussion. First, who are the infants who should receive home monitors? Some infants, such as those with a tracheostomy, have an increased incidence of sudden death at home. Monitoring these infants seems reasonable. Other groups of infants are presently being monitored with less evidence of the monitor's efficacy. Second, should physicians in West Virginia take a unified approach in evaluating patients who may need monitors?

Who is the 'High-Risk' Infant?

Who is the infant at risk for sudden unexpected death? In the last 20 years researchers have explored the possible causes of Sudden Infant Death syndrome (SIDS). No single theory encompasses all cases;[10] therefore, prevention of SIDS has been impossible.

Guntheroth believed there may be conditions detectable which indicate a child is at risk for dying suddenly and unexpectedly. In 1972, Steinschneider described two infants in whom SIDS occurred within hours after documented high rates of periodic breathing and apneic spells.[11] He felt certain infants may have impaired breathing control, and may be at greater risk for sudden death. Whether there are abnormalities of respiratory control in infants which can be detected is a matter of conjecture.[12,13] In fact, there are over 100 divergent theories about why infants die suddenly and unexpectedly.[10]

In the last several years, numerous articles have been written regarding the diagnosis of "near-miss SIDS."[15] Unfortunately, the definition of near-miss SIDS is subjective. "The label is based on a subjective, emotional response evoked in the observer (usually the parents), in particular, the feeling that the infant's death was imminent and was 'nearly missed,'" comment Guilleminault and Korobkin.[16] "Independent of any notion of pathophysiology," they continue, "the 'near-miss' group may have greater morbidity than controls. The data to support this assumption are still meager, and the point requires more study."

Most times all we know is that these infants have experienced an unexpected, possibly life-threatening, event. We do not know how close they were to death. We do not know if a similar event will recur. Neither parental history, physical examination, nor testing of any type seems to be predictive of sudden death in the child who has these events.[17] So the "near-miss" infant may or may not be high-risk for SIDS.

The incidence of SIDS in the normal population is two deaths per 1,000 live births. Other groups of infants do have a slightly higher incidence of SIDS. These include siblings of SIDS victims,[18] infants of methadone addicts, and premature babies with bronchopulmonary dysplasia.[19] Even though there is an increased incidence of SIDS in these groups, greater than 96 per cent will be survivors of infancy without any intervention.

Can any intervention raise the percentage of survivors in any group? When an infant dies, he both stops breathing and his heart stops beating; therefore, one *could* argue that an infant "at risk" for SIDS should be under surveillance at all times to be sure that he is breathing and his heart beating. Electronic monitors are available for surveillance in hospital or at home; however, there is no prospectively controlled data which shows that such monitors in the home save lives in any group studied.[17]

Though the efficacy of monitoring is unproven, there are circumstances when a physician feels that surveillance with a home monitor is best for a particular infant.[8] General guidelines for evaluation of these infants are extensive and complicated, but are available.[16,20]

Home Monitoring in West Virginia

In West Virginia today, many infants are monitored at home. Besides being costly and emotionally draining for all concerned, these infants present several problems in management. Many present with a history of unexpected, possibly life-threatening, events such as an apneic spell or other similar condition. The general practitioner rarely can amass the experience to deal comfortably and effectively with the subtleties experienced in this unusual group of patients.

In addition to a thorough history and physical examination, these patients often require specialized studies such as CT scan, esophageal pH monitoring, echocardiography, measurement of respiratory function, and detailed developmental assessment. Only a few tertiary care pediatric centers are equipped to provide this standard of care while collecting necessary data on this unusual group of patients. In fact, the current patient care information is so massive that it requires continuing education of the physician who has a primary interest in SIDS.

The Table lists components for optimal home monitoring. Omission of any steps can result in greater difficulty for the parents or physician. Therefore, a unified approach for these patients seems logical. Centers which would assume high standards in evaluation and care of these patients as previously outlined could be established in our state. If home monitoring of the infant is necessary, these centers ideally could make the experience as palatable as possible for all involved.

TABLE

Essentials of Home Monitoring

1.	Complete in-hospital evaluation (specialized testing as necessary)
2.	Thorough discussion with parents and extended family to assure compliance and support
3.	Thorough CPR training with "resusi-baby" and demonstration of parents' skills
4.	Letter to emergency services closest to the family home to alert them to a possible problem
5.	Letter to electric company that family should be a priority customer
6.	Assured telephone access
7.	Thorough in-service training about use of monitoring equipment and training in keeping a log
8.	24-hour, on-call medical equipment servicing and 24-hour physician on call.
9.	Assured, trained baby-sitting backup to allow parents time away from the baby and monitor
10.	Plan for continued assessment of the infant
11.	Plan for discontinuance of the monitor

In addition, epidemiologic trends and outreach education for professionals and lay persons alike could be developed from the experiences gained from such a collaborative effort. It would appear to be in our collective interest to better organize our efforts in this area.

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Career Choices, Accomplishments: Women Graduates Of West Virginia University School Of Medicine

RUTH M. PHILLIPS, M. D.
Associate Professor in Pediatrics, West Virginia University School of Medicine, Morgantown

Questionnaires, consisting of 24 items, were sent to 142 women graduates of the West Virginia University Medical School in order to compare their career accomplishments and lifestyles with a similar, but more complex, survey conducted by Dr. Marilyn Heins on women graduates of Wayne State University. One hundred and four (76 per cent) of the WVU graduates responded. Results of the survey are similar to the Wayne State University data in that the majority of graduates are married and working full-time with little, if any, domestic help. However, comparatively more of the WVU graduates are employed in a hospital (56 per cent) and/or medical school setting (33 per cent).

One third of the women completing their residency programs hold faculty positions in medical schools, and 65 per cent of the graduates completing at least three years of residency training are board certified.

The majority of the women plan to work indefinitely.

The 1970s saw an impressive increase in the number of women admitted to medical schools, and the total number increased from 3,639 (9.1 per cent of total enrollment in 1970-71) to 16,955 (26.2 per cent in 1980-81).[1] Factors responsible for the increase, in addition to the growing acceptance by women, and others, of professional careers available to women, include the enactment of legislation providing equal opportunity in the educational setting, and overall expansion in medical education in this country.

Current data indicate a more equal distribution of women in our medical schools than that which existed a decade ago.[2] In spite of the increased acceptance of women in medicine, however, there still is the often expressed concern that the medical education of women is not an optimal investment. In 1928, Tracy[3] published survey data indicating that a higher percentage of women (9.1 per cent) than men (0.05 per cent) ceased to practice medicine, and in 1968, Phelps[4] suggested that women devoted less time than men to the practice of medicine because of the demands of raising a family.

Recognizing the need for a more comprehensive study, Marilyn Heins, M.D., former Associate Dean for Student Affairs at the Wayne State University School of Medicine, recently conducted a survey consisting of a 207-item questionnaire administered to graduates of that school.[5]

The typical woman in her data was 46 years of age, was married most likely to a physician, and had two and one half children. She was employed full-time and had worked continuously since graduation from medical school. She was board certified in one of the primary care specialties and was concerned chiefly with patient care. She was self-employed in a private office with median earnings of $36,800 per year and earned considerably less than her male counterpart. She worked long hours and very well in the dual roles of full-time physician and homemaker with little child care and domestic help.

The Heins survey led us to investigate the accomplishments and lifestyle of the women medical graduates of WVU.

Method and Results

With the cooperation of the Deans of the School of Medicine, a similar but simpler questionnaire, consisting of 24 items, was sent to the 142 graduates of the medical school. Of these, 108 (76 per cent) responded. The sample consisted of all women awarded a medical degree from 1962 through 1982. Following expansion from a two- to a four-year medical school, the University awarded its first M. D. degree in 1962. WVU is a land grant institution and, with rare exception, medical students are residents of the state.

Geographical Distribution:

Forty-four (41 per cent) of the 108 women, including 17 residents, currently live in West Virginia. Six (0.06 per cent) completed a portion, or all, of their residency training at WVU and now reside out of state. Fifty-five (51 per cent), including 21 resident staff, obtain, or have obtained, their postgraduate training elsewhere and also are living out of state. Three women indicated no residency training.

Forty-nine (45.4 per cent) are living in large urban areas; 59 (54.6 per cent) live in moderate-size cities and small towns with only a few living in semi-rural areas. Forty-two graduates (39 per cent), not including women in their residencies, are practicing in the state where they obtained their residency training.

Marital Status and Husbands' Occupations:

The majority of the women graduates are married to men in the professions, chiefly physicians, as shown in Tables 1 and 2.

Children, Domestic Help and Child Care:

Seventy of the 108 graduates are married and 38 are unmarried. In 42 families of the married graduates, there are 75 children with ages ranging between three months to 22 years. Child care help (minimal) and household help (usually for one day per week or less) are available in only 24 and 25 of the households, respectively. In six families of the unmarried graduates (parents divorced), there are 15 children with child care help in four, and household help in two.

Occupation of the Parents:

Perseverance to final accomplishment is related to the inner personality core of women entering a medical career. Mandelbaum[6] analyzed the motivation and career persistence of 71 women physicians and found one factor to be of great importance: motivation, sustained chiefly through early influences by family, particularly parents, and exposure to teachers in the early school years. One might anticipate a high incidence of professional occupations in the parents of the women graduates. Table 3 documents the occupations, and it is of interest that the majority of the fathers are in nonprofessional occupations and that approximately one half of the mothers are housewives. Of those mothers in occupations, only one half are employed professionally.

Postgraduate Training and Specialty Choices:

Sixty-six (61 per cent) of the graduates have completed their medical training; 38 are in their postgraduate residencies, and four are in fellowship programs. Major specialty choices, in order of preference, are psychiatry, anesthesiology, internal medicine, family practice, pediatrics and pathology.

Sixty-nine (63.9 per cent) of the women expressed satisfaction with their original specialty choice selections, but 39 (36.1 per cent) were not satisfied and made a change. Changes were chiefly to emergency medicine, family practice, pediatrics, psychiatry and radiology. Twelve women (30.8 per cent of those changing specialties) selected emergency room medicine, citing limited hours and improved income as their chief reasons.

Specialty Board Certification:

Forty of the graduates, or 65 per cent of the 62 women completing at least three years of residency training, are certified by specialty boards as documented in Table 4.

TABLE 1

Marital Status of the 108 Women Graduates

Married	70
Unmarried	38
Divorced	14

4 divorced once and remarried
1 divorced twice and remarried twice

Total married, 64.8%
Total unmarried, 35.2%
Total divorced, 13.0%
Total divorced and remarried, 4.6%

TABLE 2

Occupations of the Husbands of the Women Graduates

	Number	*Percentage*
Professional	55	78.5
Nonprofessional	15	21.5

Women married to physicians – 60%
(With 70 of the graduates responding)

TABLE 3

Summary of Occupations of the Parents of the Women Graduates

	Professional	*Nonprofessional*
Fathers	31 (28.5%)	73 (67.8%)
	Retired	*Deceased*
	2 (1.9%)	3 (2.8%)
Mothers	32 (29.6%)	33 (30.6%)
	Housewives	
	43 (39.8%)	

TABLE 4

Certification by Specialty Boards

Internal Medicine	11	Psychiatry	2
Family Practice	7	Radiology	1
Pediatrics	6	Pathology	1
Anesthesiology	5	ENT	1
OB-GYN	3	Neurology	1
Cardiology	2	TOTAL	40

(65%, or 62 women, completing at least 3 years of residency training)

Present Occupation:

Excluding women in residency and fellowship programs, fifty-one (77.3 per cent) of the women are in full-time occupations, and the remainder are working part-time. Thirty-six (56 per cent) are hospital-based, and 22 (33 per cent) are employed by medical schools. Thirteen (19.7 per cent) indicate they work in private offices full-time or part-time and are self-employed (Table 5). Of the 99 women responding to this item in the questionnaire, 68 (69 per cent) indicate they work at least 50 hours per week, and 34 (34 per cent) indicate they are employed at least 60 hours per week.

Medical School Faculty Positions:

Twenty-two of the women graduates hold faculty positions in medical school, 14 of them full-time. This represents one third of the women who completed residency and/or fellowship programs. Of those holding full-time faculty positions, three are Associate Professors, eight are Assistant Professors and three are Instructors. One woman graduate (deceased) held the full-time position as Director of a Family Practice residency program. One woman graduate holds the position of Associate Dean for Student Affairs at Columbia University Medical School.

Time Off from Occupation:

Few of the women physicians have taken time off, or plan to do so, from their careers. Reason for taking time off is primarily for raising a family. Other reasons cited are for illness, for other personal reasons or for further medical training. Two of the graduates interrupted their careers for periods up to two years. One graduate, apologetically, indicated she is temporarily a housewife, working professionally one hour weekly.

Estimated Annual Income:

Ninety-nine of the women responded to this item in the questionnaire. The average gross annual income (before taxes) of the responding physicians is $61,000. This is an estimated one third less than the earnings of their male counterparts.

Job Motivation:

The two most important reasons given for working were that women enjoy working (68 per cent) and that they wish to continue their careers (67 per cent). Income is very important to only 11 per cent and of far less importance to 58 per cent.

Career Satisfaction:

In answer to the question "If *not totally satisfied* with your present career situation, can you state why?," a surprisingly large number of the women, namely 44, expressed dissatisfaction with their chosen careers, 47 withheld comment, and only 17 indicated complete satisfaction. Reasons given for dissatisfaction were: 1) the work is too demanding physically and emotionally, 2) the hours are too long and unpredictable, and 3) there is not enough time for family and personal growth.

Retirement Plans:

Although 26 women (24 per cent) plan to retire at the age of 62 or 65, almost one half of the graduates (46, or 43 per cent) indicated the desire to continue working indefinitely. Sixteen (15 per cent) plan to work part-time after the age of 65.

Discrimination against Women, and the Women's Movement:

Approximately one half of the graduates felt that there was, in their experience, discrimination

TABLE 5

Present Occupation of 108 Female Graduates of WVU School of Medicine

Age Range	*Full Time*	*Part Time*	*Hrs/Wk*	*Private Office*	*Hospital*	*Clinic*	*Medical School*	*Industry Government*	*Self-Employed Alone*	*Group*
25-30	2	2	44-60	2	3	1	–	–	–	3
30-35	23	3	8-80	8	13	2	10	–	3	9
35-40	13	4	20-80	6	8	2	7	–	6	6
40-45	12	6	1-75	3	11	1	5	3	4	4
45-50	–	–	–	–	–	–	–	–	–	–
Over 50	1	–	40	–	1	–	–	–	–	–
TOTAL	51 (77.3%)	15 (23%)	1-80	13 (19.7%)	36 (56%)	6 (9%)	22 (33%)	3 (4.5%)	13 (19.7%)	22 (33%)
Residents & Fellows	42	–	–	–	42	–	42	–	–	–
TOTAL	93 (86.1%)	–	–	–	78 (72.2%)	–	64 (59.2%)	–	–	–

against women. The majority (80 per cent) were supportive of the Women's Movement for Equal Rights but 16 per cent had reservations. Many felt the movement to be too militant and too radical.

Discussion

Results of the WVU survey are very similar to the Wayne State University data. Ninety-three (86.1 per cent) of the WVU women graduates are employed full-time and have worked continuously since graduation. The majority are married to physicians and have 1.8 children. Although many expressed dissatisfaction with their careers, most plan to work indefinitely with little time off for personal reasons.

Unlike Doctor Heins' study, most of the WVU graduates are employed in a hospital and/or medical school setting. One third of the women completing their residency programs are in academic settings and hold faculty positions in medical schools. One of the women graduates holds an administrative position in a medical school.

Conclusion

The women physicians in this study work hard in the dual roles of a demanding profession and the responsibility for running a home. Many feel they suffer from work overload and role conflict, and have little time for themselves. Yet few of the women seem to recognize the almost super-human requirements of the dual roles. Most of these highly motivated and high-energy-level women have achieved fulfillment and satisfaction in both.

The results of the survey indicate that the training of women at WVU School of Medicine is indeed an optimal investment.

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You can do very little with faith, but you can do nothing without it.

— Samuel Butler

The President's Page

Guest Author
Alice B. (Mrs. T. Keith) Edwards, President
Auxiliary to the
West Virginia State Medical Association

WE CARE

The West Virginia State Medical Association Auxiliary exists because of you, the members of the Medical Association. As spouses of physicians, we are vitally interested in all that relates to you and your work. When your image is marred, so is ours; when your rights of practice are threatened, our domains are unstable; and when malpractice threats invade your lives, our world is no longer secure. As Auxiliary members, we are brought together by common interests in you and in the Health Profession.

We care about legislation. We are perennially interested in the legislation pertaining to Health Practice. Our Legislative Chairman, Mrs. Harry Shannon, keeps up with West Virginia's legislative action. Through our Legislative Alert System, she keeps Auxiliarians at the county level informed and involved.

AMA-ERF is our project nationally and locally to support Medical Education. Last year our raffles, benefits, Christmas card sales, Country Stores, and Bonnet Buffets netted us over $24,000 for AMA-ERF. This year we plan to donate even more. We care about Medical Education.

Our membership decreased slightly last year. Our goal in 1983-84 is to regain the lost members, and to increase our numbers. If your spouse is not active in Auxiliary, please encourage him or her to join the local Auxiliary group. I promise you he or she will meet a group of friendly, caring persons who are interested in making good health happen. If there is not a county auxiliary in your area, being a member-at-large is an excellent way to be a part of the Auxiliary. For information on membership, contact Mrs. Harry Weeks, Jr. (Esther), Membership Chairman, 1 Hazelett Court, Wheeling 26003. Our dues are unbelievably low. State membership costs $8 and national membership is only $15. The county membership varies from county to county, and this also is a very reasonable amount. We care about Auxiliary growth and involvement.

The "Shape Up For Life" theme is almost synonymous with Auxiliary. This theme takes on a new facet yearly as we consider various aspects of physical and emotional involvement in shaping up for life. This year our emphasis is on Drunk Driving and Child Abuse. We are involved in promoting "The Chemical People" on Public Broadcasting System in November. We conducted a workshop on Drunk Driving at our Fall Board Meeting on October 26. Our speaker was the Honorable Virginia Roberts, Commissioner of Motor Vehicles. In March, West Virginia Auxiliary will cooperate with the Auxiliaries from Virginia and Maryland to hold a Tri-State Meeting on Child Abuse. We are targeting county officers, especially Health Projects Chairmen, to attend this meeting. We care that many people needlessly die because of drunk drivers. We care that child abuse ranks among the top health problems in our nation. We want to promote better health in these areas.

As Auxiliary President, I pledge our cooperation and care in promoting good health for West Virginia.

Alice B. Edwards

The West Virginia Medical Journal

Editorials

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author shall be held entirely responsible. Editorials printed in The Journal do not necessarily reflect the official position of the West Virginia State Medical Association.

AWAKE AND AWARE

Donald C. Bell, M.D., writing in his role as President of the Minnesota Medical Association, has outlined what he calls significant similarities between the medical profession and the military.

Both professions deal with matters that range from disruptive to catastrophic in their effect on our lives. Both deal with expenditures of huge amounts of money, which expenditures are regarded as burdensome by the body politic.

Both professions deal with affairs that are difficult to assess from a cost-effective perspective. The only value of a tank is when it helps to win a battle, and who can assess the real value of a bilateral total knee replacement in an elderly woman in economic terms? No one wants war, and no one wants to be sick.

Looking at some history, Doctor Bell found three problems that had a profound influence in the World War II disaster at Pearl Harbor. At least in part, military leaders didn't understand their real mission. They had a "mind set" that the Japanese could not and would not attack Hawaii. And there was a dichotomy between the Army and Navy that prevented effective cooperation.

Doctor Bell thinks that in this time of "great stress for the medical profession," it's possible to find the same three negative factors in ranks of physicians. Amid recognition that Medicine's mission is to try to prevent illness and treat it when it occurs, he finds some who think Organized Medicine's mission is to preserve the profession's status in a position of primacy in the health care field.

The Minnesota physician suggests that doctors' true mission is to strive to provide the best available health care for all members of society, in all circumstances. In the process of fulfilling that mission, physicians' primacy likely will best be preserved.

He also has found a "mind set" among some that business as usual ever will prevail, and physicians can't be replaced. Doctor Bell observes that doctors already have been *displaced* a great deal from direct involvement in health planning, and to some degree in health care delivery itself. Here, the best defense against *being* replaced is to believe and act as though physicians *could* be.

Doctor Bell's conclusion is that all segments of Medicine need each other. He singled out the practicing and teaching hospital physicians; the fee-for-service community as well as those in prepaid health plan; and the city and rural-based doctors.

Dichotomies must be avoided, because they are differences with chasms between opposite points of view, chasms that prevent effective communication. A view across a chasm never allows for a realistic appraisal and understanding of the ground on which the other person stands.

Persons with whom one might differ likely have intellectual capacity, ethical standards and good will equivalent to one's own. Differences are in perspectives, and Doctor Bell suggests that on occasion, others might be right in what they say.

He has expressed a hope for Minnesota physicians consistent with that which has become a philosophical cornerstone among leaders in the West Virginia State Medical Association. The hope is that as the years go by, physicians can deprive some enterprising writer of the chance to write a book that might be entitled, "In the Evening of Their Profession—They Slept."

RECORD OF SERVICE

He looked around at the glitter of the hotel lobby-casino in Las Vegas, and opined that "I'd like to own the electric company out here."

He was served a hot taco at a California Medical Association reception in San Francisco and later said that, when he put a cigarette in his mouth, "it lit on both ends without a match."

That is the lighter side of Frank J. Holroyd, M. D., of Princeton, whose life for 32 years

(1952-1983 inclusive) has centered about his role as a Delegate to the American Medical Association House.

But there has been a consistently serious side, too. No one can recall that Doctor Holroyd ever missed a House session in setting what stands as a clear record for AMA service, both overall and continuous.

Along with his AMA service, Doctor Holroyd has been President of the State Medical Association, and for years has had leadership roles in legislative and West Virginia Medical Political Action Committee (WESPAC) activity.

In the smoke and fire of AMA politics, a key element of organized medicine activity, he literally has been a giant. Candidates for every type of office from an AMA council to President Elect have sought his guidance, support and direction.

His crowning achievements perhaps came in 1970 and 1971. He was a key figure in managing successfully, for AMA President Elect, the candidacy of the late Wesley W. Hall, M. D., from the one-delegate state of Nevada in 1970.

A year later came the election as President Elect of the late C. A. (Carl) Hoffman of Huntington—from two-delegate West Virginia. Doctor Hoffman, in serving as President in 1972-73, is the only West Virginia physician to hold the highest AMA office.

Doctor Holroyd will be the first to note, however, that "first, some years earlier, we had to get Carl elected to the Board of Trustees." Doctor Hoffman also served as the AMA's Secretary-Treasurer.

For many years, a vacation from his practice has meant for Doctor Holroyd attendance at an AMA meeting. Through action taken by the State Medical Association's House of Delegates in August, he can continue that regimen.

While he will be succeeded in 1984 by Jack Leckie, M. D., of Huntington as a West Virginia Delegate, along with Harry S. Weeks, Jr., M. D., of Wheeling, Doctor Holroyd can attend the AMA sessions as an honorary member of the West Virginia delegation, with his expenses paid.

Stephen D. Ward, M. D., of Wheeling, now completing a nine-year stretch on the AMA's Commission on Legislation, made the appropriate motion on behalf of Doctor Holroyd, and added a glowing tribute to his long period of service.

Doctor Holroyd's straight-faced response was typical.

"I had some trouble figuring out just what bird Steve was talking about," he said.

For Medicine and others interested in patient care, it was more of the same as Congress moved into the final weeks of its 1983 session — another object lesson in why an informed physician population, working together, is so essential.

SAME OLD STORY

While, unfortunately, too many doctors still chose to turn their backs on day-by-day reality outside their offices, Congress set out anew to find $400 million in Medicare and Medicaid reductions in fiscal 1984 ($1.7 billion over the next three years).

Fine, you say. A budget resolution doesn't say where the savings are to be achieved, other than to mandate that they are to come mostly from Medicare; but are not to be achieved through higher costs paid by Medicare patients.

The Senate Finance Committee agreed, before its August recess, to two Medicare changes to save the $1.7 billion. One would freeze until July 1, 1984, prevailing charge limits in effect July 1, 1983, for all physician services. Another would set permanently at 25 per cent of total program income the proportion of Part B (physicians services) Medicare costs paid by enrollee premiums.

The Senate committee proposed to use these savings to finance block grants to states to subsidize health insurance for unemployed workers. Medicare cuts pending in the House at this writing would impose a six-months freeze on physician payments.

Also still on the stove was the future of health planning. The best guess at this writing has pointed to a compromise to retain federal support for state planning efforts through another block grant approach.

Legislation to reauthorize the National Institutes of Health has generated controversy, at least on the House side, by proposing to set certain priorities for research and raising charges that scientific decisions could be politicized.

And yes, the Federal Trade Commission issue is still alive. The Senate might buy FTC staff-American Medical Association compromise language to prohibit the FTC from using its authority to pre-empt state laws that establish training, education or experience requirements for professional licensure, or that establish the permissible tasks that professionals may perform. Also, the FTC could not challenge as unfair competition any method of competition required and supervised by a state. The House version, meanwhile, contains a modification of the FTC-AMA agreement not acceptable to the AMA.

GENERAL NEWS

Program Topics Sigmoidoscopy, Children of Divorce

Children of divorce and flexible sigmoidoscopy will be discussed during the opening Friday afternoon session of the 17th Mid-Winter Clinical Conference next January 27-29.

To be held again at the Charleston Marriott Hotel, the week-end continuing education event is sponsored by the State Medical Association

Arthur E. Kelley, M. D.

Ronald D. Gaskins, M. D.

and the Marshall and West Virginia University Schools of Medicine.

Dr. Arthur E. Kelley of Morgantown will speak on "Children of Divorce: Problems and Solutions," and Dr. Ronald D. Gaskins, also of Morgantown, will present the paper on "Flexible Sigmoidoscopy." the Program Committee announced.

The conference, featuring some 18 physician and other speakers, will begin at 2 P. M. on Friday, January 27, and end at noon on Sunday. Scientific sessions are scheduled Friday afternoon, Saturday morning and afternoon, and Sunday morning. As usual, special concurrent sessions for physicians and the public are scheduled Friday evening.

In addition to speakers and topics announced previously, other papers will deal with epilepsy, disc disease and arthritis.

Doctor Kelley is WVU Associate Professor, Psychiatry and Child Psychiatry, Department of Behavioral Medicine and Psychiatry. In addition to teaching duties, he conducts outpatient and inpatient therapy for children, adults and families.

Other Positions

Doctor Kelley holds the Department administrative positions of Chief of Child and Adolescent Programs, and Director of Liaison Services, Morgantown and Charleston Divisions, WVU. He also is Assistant Clinical Professor, Department of Nursing, University of Charleston.

The Pittsburgh native has made a number of presentations on children and youth before medical and governmental groups, and is the author of "Psychological Problems of Preadolescents," appearing in *Proceedings of the West Virginia Conference on Middle School Education* in May, 1979, and "Group Therapy for Abusing Parents and their Children," *Journal of Specialists in Group Work*, in 1981.

Doctor Kelley received his undergraduate and M. D. (1974) degrees from WVU, and completed a residency and fellowship in behavioral medicine and child psychiatry, respectively, at WVU Charleston Division.

Doctor Gaskins is WVU Associate Professor, Department of Medicine, Gastroenterology Section, and Gastroenterology Section Chief at WVU Hospital. He is a member and Director of Continuing Medical Education for the West Virginia Gastrointestinal Society, and recently has been Co-Director of Flexible Sigmoidoscopy courses sponsored jointly by the Society and the West Virginia Chapter. American College of Surgeons.

Medical Training

Born in South Carolina, Doctor Gaskins was graduated from the College of Charleston (South Carolina), and received his M. D. degree in 1962 from the Medical University of South Carolina. He interned at the Naval Hospital in Philadelphia, and completed a residency in internal medicine and a fellowship in gastroenterology at the Naval Hospital, National Naval Medical Center, Bethesda, Maryland.

A program on disability, "Into and Out of the Disability Trap," as announced previously, will constitute the entire Saturday afternoon session.

The format will feature an in-depth panel discussion, emphasizing audience participation, on the physician and procedures and pitfalls in disability determination. The panel (to be announced) will include an employer's attorney, an attorney familiar with claimants' cases, disability officials from state and federal agencies, and an independent rehabilitation representative.

"West Virginia Board of Medicine Update," an informative presentation on the activities and problems of that Board, is scheduled for the Friday evening physicians' session; and "Rape and Incest: The Hidden Crisis," will be the title for the concurrent public session. (See separate story on the public session in this issue of *The Journal.*)

Other Speakers, Topics

Other speakers and topics, as announced previously, will be:

"AIDS"—James N. Frame, M. D., third-year resident, internal medicine, Charleston Area Medical Center/WVU Charleston Division (Friday Afternoon); "Parkinsonism and Organic Brain Syndrome"—Albert F. Heck, M. D., Charleston, WVU Clinical Professor of Neurology, and "Geriatric Pharmacology"—Mary Beth Gross, Pharm. D., Assistant Professor of Clinical Pharmacy, WVU Charleston Division (Saturday morning); and "Intracoronary Thrombolysis: Clinical Experiences to Date"—Joseph F. Hanna, M. D., Assistant Professor of Medicine and Director of Invasive Cardiology, MU School of Medicine and Veterans Administration Medical Center, Huntington (Sunday Morning).

The program meets the criteria for 14 hours of credit in Category 1 of the Physician's Recognition Award of the American Medical Association, and also is approved for 14 Prescribed hours by the American Academy of Family Physicians.

Fees, Registration

A registration fee of $50 will be charged all registrants except nurses, medical students, interns and residents. For advance registration, make checks payable to West Virginia State Medical Association, and mail to the Association at P. O. Box 1031, Charleston 25324.

The Charleston Marriott is holding a block of rooms for conference attendees, and reservations should be made by January 6. Those who register for the conference in advance will receive from the Association a postage-paid Marriott reservation request card specifically designated for the conference. Persons making reservations directly with the hotel—in order to receive group rates—should specify that they will be attending the Mid-Winter Clinical Conference. Group rates are $52 for a single room and $60 for a double.

Program Committee

Members of the Program Committee are Drs. Joseph T. Skaggs, Chairman; William O. McMillan, Jr., and C. Carl Tully, all of Charleston; Richard G. Starr, Beckley; Maurice A. Mufson, Huntington, and Robert L. Smith, Morgantown.

The Program Committee is receiving continuing assistance from WVU Charleston Division staff members J. Zeb. Wright, Ph.D., Coordinator of Continuing Education, Department of Community Medicine; and Sharon A. Hall, Conference Coordinator.

Additional speakers and program details will be presented in the December and January issues of *The Journal.*

Interim Meeting Of AMA House In December

The 1983 Interim Meeting of the House of Delegates of the American Medical Association will be held December 4-7 in Los Angeles.

West Virginia's delegates to the AMA House are Drs. Frank J. Holroyd of Princeton and Harry S. Weeks, Jr., of Wheeling, with Drs. Jack Leckie of Huntington and Joseph A. Smith of Dunbar serving as Alternate Delegates.

Dr. Stephen D. Ward of Wheeling serves on the AMA Council on Legislation, and West Virginia University medical student David J. Brailer of Morgantown is on the Council on Long Range Planning and Development.

The official call for the meeting was published in the October 7 issue of the *Journal of the American Medical Association.*

The 351 delegates will represent state medical associations, national medical specialty societies, resident physicians, medical students, medical schools, hospital medical staffs, the military service medical units, the U. S. Public Health Service and the Veterans Administration.

The AMA Auxiliary will convene simultaneously with the AMA.

Delegates to the Interim Meeting will consider a wide variety of resolutions and reports dealing with all aspects of medical science.

Continuing Education Activities

Here are the continuing medical education activities listed primarily by the Marshall University and West Virginia University Schools of Medicine for part of 1983 and 1984, as compiled by Charles W. Jones, Ph.D., MU Director of Continuing Medical Education; Robert L. Smith, M. D., WVU Assistant Dean for Continuing Education, and J. Zeb Wright, Ph.D., Coordinator, Continuing Education, Department of Community Medicine, WVU Charleston Division. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of The Journal.)

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the WVU Morgantown, Charleston and Wheeling campuses. Further information about CME activities may be obtained from: Office of Continuing Medical Education, MU School of Medicine, Huntington 25701; Division of Continuing Education, WVU Medical Center, 3110 MacCorkle Avenue, S. E., Charleston 25304; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 200 Eoff Street, Wheeling 26003.

Marshall University

Nov. 2, The Calcium Antagonist

Nov. 4, Infection Control in the Tri-State Area (co-sponsored by WV Assoc. for Practitioners in Infection Control)

Dec. 10, Sports Medicine Conference: A Program for Primary Care Practitioners

West Virginia University

Nov. 3-5, Morgantown, Ninth Annual Hal Wanger Family Practice Conference*

Nov. 11-12, Morgantown, Fourth Sports Medicine Symposium*

Nov. 14, Charleston, Medicine and Ministry in Cooperative Patient Care

**Held in conjunction with WVU home football game.*

1984

Jan. 23-27, Snowshoe, 5th Mid-Winter Cardiovascular Symposium (Charleston Division)

Feb. 19-22, Snowshoe, Second Annual Vascular Surgery Conference

Regularly Scheduled Continuing Education Outreach Programs from WVU Medical Center/ Charleston Division

Buckhannon, St. Joseph's Hospital, first-floor cafeteria, 3rd Thursday, 7-9 P. M.—Nov. 17, "High-Risk Communicable Diseases and the Health Worker," Patrick Robinson, M. D.

Dec. 15 (Vacation)

Cabin Creek, Cabin Creek Medical Center, Dawes, 2nd Wednesday, 8-10 A. M.—Nov. 9, "Outpatient Orthopedic Injuries," W. G. Sale, M. D.

Dec. 14, "Common Outpatient Dermatological Problems," Donald E. Farmer, M. D.

Gassaway, Braxton Co. Memorial Hospital, 1st Wednesday, 7-9 P. M.—Nov. 2, "Update on Nuclear Medicine," Steven Artz, M. D.

Dec. 7, "Management of Acute Cardiac Emergencies" (speaker to be announced)

Jan. 4, "Management of Pulmonary Distress," George L. Zaldivar, M. D.

Madison, 2nd floor, Lick Creek Social Services Bldg., 2nd Tuesday, 7-9 P. M. — Nov. 8, "Stress-Related Gastrointestinal Disorders," Warren Point, M. D.

Dec. 13, "Recently Recognized and Sexually Transmitted Diseases," Thomas W. Mou, M. D.

Oak Hill, Oak Hill High School (Oyler Exit, N 19) 4th Tuesday, 7-9 P. M. — Nov. 22, "Sudden Infant Death Syndrome," David Z. Myerberg, M. D.

Dec. 27 (Vacation)

Princeton, Community Hospital Board Room, 4th Thursday, 6:30-8:30 P. M. — Nov. 24 (Thanksgiving Day)

Dec. 22 (Vacation)

Welch, Stevens Clinic Hospital, 3rd Wednesday, 12 Noon-2 P. M. — Nov. 16, "What Other Health Professionals Should Know About Surgery: Pre- and Post-Update," S. Willis Trammel, M. D.

Dec. 21 (Vacation)

(continued on next page)

Whitesville, Raleigh-Boone Medical Center, 4th Wednesday, 11 A. M.-1 P. M.—Nov. 23 (Vacation)

Dec. 28 (Vacation)

Williamson, Appalachian Power Auditorium, 1st Thursday, 6:30-8:30 P. M.—Nov. 3, "Pediatric ENT Problems," Ronald Wilkinson, M. D.

Dec. 1, "OB Emergencies," Louis Sanchez-Ramos, M. D.

Neurological Diseases Topic For Clarksburg Seminar

Clarksburg will be the site for a three-day Neurological Diseases seminar next March 30-April 1.

Sponsors are the departments of Pathology and Staff Development, United Hospital Center.

Designed for practicing pathologists, neurologists, neurosurgeons and other interested physicians, the course will be held at the Sheraton Inn.

The opening Friday, March 30, morning session is for nurses who are involved in the care and treatment of neurological patients. The nurses will join the physicians for the remainder of the seminar, which will conclude at 3 P. M. Sunday.

The guest faculty will include Drs. Nitya R. Ghatak, Professor of Neuropathology, Medical College of Virginia; Bernard Lemieux, Chief of Pediatric Neurology, Sherbrooke University Hospital Center, Sherbrooke, Quebec, Canada; Sydney Schochet, Professor of Neuropathology, West Virginia University Medical School, Morgantown, and Harry M. Zimmerman, Emeritus Professor and Chairman of Pathology, Albert Einstein Medical College and Montefiore Hospital and Medical Center, Bronx, New York.

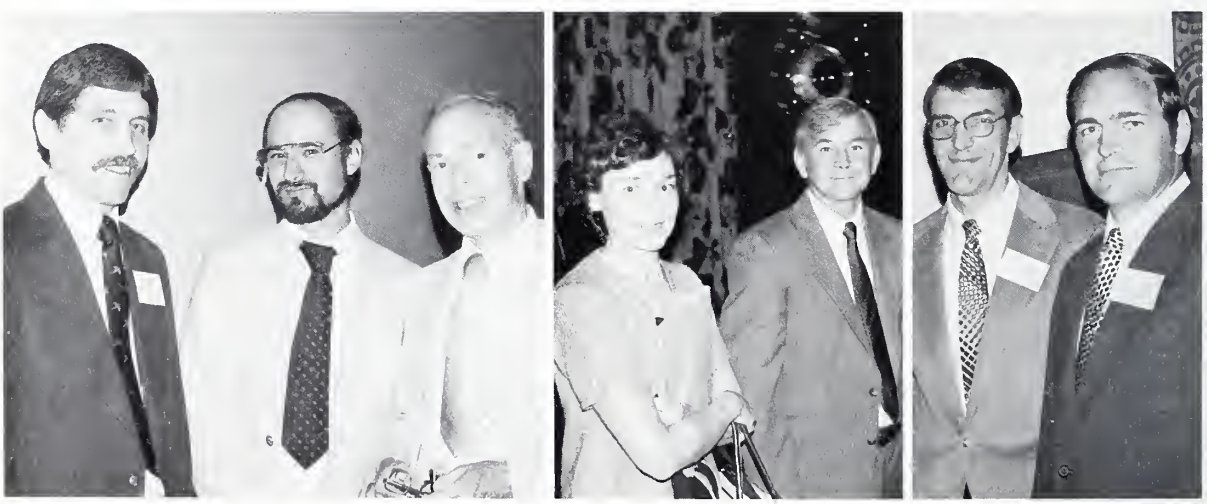
Seminar Information

The seminar has been approved for 15 hours in Category 1 of the Physician's Recognition Award of the American Medical Association; 15 Prescribed hours by the American Academy of Family Physicians, and 17.5 Contact hours by the West Virginia Nurses Association.

A block of rooms has been set aside at the Sheraton Inn until February 28.

Registration fees, which cover coffee, three lunches, and cocktails and dinner on March 31, will be $75 for physicians; $45, registered nurses; $30, residents and interns (plus $15 for banquet), and $10, students (plus $15 for banquet). Spouses are invited to cocktails and dinner on March 31 for a $15 fee.

For additional information, contact the Course Director, Dr. Chinmay K. Datta, Department of Pathology, United Hospital Center, Clarksburg 26301. Telephone (304) 624-2309.



In the left photo, Dr. Lee P. Van Voris (left) of Erie, Pennsylvania (formerly on the Marshall University School of Medicine staff), chats with two Huntington doctors, Jack M. Bernstein (center) and William L. Neal, during the State Medical Association's 116th Annual Meeting in August in White Sulphur Springs at the Greenbrier. Doctor Van Voris was a speaker on sexually transmitted diseases for the first general session. Shown prior to the first session of the Association's House of Delegates during the convention (center) are Drs. Jean P. Cavender of Charleston, a member of the 1983 Annual Meeting Program Committee, and Richard A. DeVaul, Dean of the West Virginia University School of Medicine. Doctor Cavender presided at the second general session on cardiovascular diseases, two of the speakers for which are shown on the right. They are Drs. Stafford G. Warren (left), Charleston, and John C. Alexander, Jr., Morgantown.

Conference Public Session Speakers Announced

Two Huntingtonians will conduct the public session on "Rape and Incest: The Hidden Crisis" during the 17th Mid-Winter Clinical Conference. it was announced by the Program Committee.

Diane W. Mufson, M.A.

William E. Walker, M. D.

The public session, which is held each year in conjunction with the mid-winter continuing medical education meeting, is scheduled for Friday, January 27, at 8 P. M. at the Charleston Marriott Hotel.

The two program presenters will be Diane W. Mufson, M. A., psychologist at the Cammack Center, Inc. for young people in Huntington, and Dr. William E. Walker, emergency department physician at St. Mary's Hospital in that city, and Associate Professor of Surgery at Marshall University School of Medicine.

Part-Time MU Instructor

Ms. Mufson's duties at the Cammack Center include adolescent evaluation, therapy, school placement and mental health screening. She has served as a part-time instructor in family relationships and prenatal and early child development in the MU Department of Home Economics, and has been guest lecturer for the MU School of Medicine Department of Psychiatry on sexual assault treatment. A graduate of the University of Vermont, she is a member of the Board of Directors of Children's Place, and a member of the Professional Advisory Board of the Prestera Center for Mental Health, both in Huntington.

Ms. Mufson, who holds an M. A. degree from Cornell University in Child and Family Development, and an M. A. degree from MU in Political Science, has held a number of other posts in the Huntington area dealing with sexual assault.

Doctor Walker, a Fellow of the American College of Emergency Physicians, is an Advance Cardiac Life Support Instructor and Advance Trauma Life Support Instructor. At Marshall, he also is Chief of the Section of Emergency Medicine, Department of Surgery, and Associate Professor, Department of Family and Community Health.

He is Medical Director, State of West Virginia Paramedic Training Program: Medical Advisor, MU Community College emergency medical technician and paramedic training programs: and Medical Advisor, City of Huntington and Cabell County Paramedic Squad.

Medical Training

Doctor Walker was graduated from Marietta (Ohio) College, and received his M. D. degree in 1968 from WVU. He interned at Norfolk (Virginia) General Hospital, and completed a residency and fellowship in emergency medicine at Cincinnati General Hospital.

The 1984 Mid-Winter Clinical Conference, sponsored by the State Medical Association and the MU and WVU Schools of Medicine, will be held January 27-29 at the Charleston Marriott. A special physicians' session will be held concurrently with the Friday evening public session. (For additional information on the Mid-Winter Clinical Conference, see story elsewhere in this issue of *The Journal.*)

Dr. Joseph T. Skaggs of Charleston, Chairman of the conference Program Committee, said the 1984 public session represents "a continuing effort by the sponsors to present each year timely and helpful topics of interest as a public service."

State Doctors Urged To Act On CME Questionnaire

State doctors are being asked to watch their mail for a questionnaire from the Office of Continuing Medical Education at the West Virginia University Medical Center.

Dr. Robert L. Smith, Assistant Dean for Continuing Medical Education, said that he and others are studying how physicians might receive credit for self-directed continuing medical education efforts based on their own practice.

"Responses to the questionnaire from as many physicians as possible are vital to this study project," Doctor Smith commented.

MU Announces Promotions, New Faculty Members

Four Marshall University School of Medicine faculty members recently have been granted tenure, and nine promoted, according to Dr. Robert W. Coon, M. D., Vice-President for Health Sciences and Dean.

Granted tenure were Drs. Mildred Bateman, Professor of Psychiatry; Susan DeMesquita, Assistant Professor of Physiology; Talmadge R. Huston, who also was promoted to Associate Professor of Family and Community Health; and Donald S. Robinson, Professor and Chairman of Pharmacology, and Professor of Medicine and Psychiatry.

Drs. Robert B. Belshe and James A. Kemp of the Department of Medicine were promoted to Professor. Promoted to Associate Professor were Doctor Huston and Drs. Robert B. Walker and William E. Walker, all Family and Community Health; Nicholas Baranetsky and Duane D. Webb, Medicine; Ramon E. Miro, Obstetrics/Gynecology, and Elizabeth D. Devereaux, Psychiatry.

Six of the school's volunteer faculty also received promotions. They are Drs. Charles E. Turner, Clinical Professor of Medicine; Thomas F. Scott, Clinical Professor of Surgery, Tara C. Sharma and K. Venkata Raman, Clinical Associate Professors of Surgery, and Panos D. Ignatiadis and John O. Mullen, Clinical Assistant Professors of Surgery.

1983-84 Appointments

Medicine: Drs. Edwin C. Anderson (also with pediatrics) and Michael D. Webb, both Associate Professors; Andrew J. Burger, Carl F. McComas, Nancy Munn, Shirley M. Neitch and Dorothy A. Snow, all Assistant Professors; *Family and Community Health*: Richard Blondell and Linda M. Savory, both Assistant Professors; Lynne Heidsiek, Instructor; *Psychiatry* — Robert A. Kayser, Assistant Professor; *Pediatrics* — Patricia J. Kelly, Assistant Professor; and *Surgery* — Anthony Horan and Stephen Wolf, Associate Professors.

Hired During 1982-83 School Year

Faculty members hired in the course of the 1982-83 school year were Drs. Joseph F. Hanna, Assistant Professor of Medicine; Geoffrey J. Gorse, Assistant Professor of Medicine; Thomas W. Kiernan, Veterans Administration Medical Center Chief of Staff and Associate Professor of Medicine; William E. Wheeler, Assistant Professor of Surgery; Hilton B. Slung, Assistant Professor of Surgery;

John Walden, Associate Professor of Family and Community Health; Mitchell L. Berk, Assistant Professor of Anatomy; Colette A. Gushurst, Assistant Professor of Pediatrics and Family and Community Health; Gregory R. Wagner, Assistant Professor of Family and Community Health and Medicine; Joye A. Martin, Assistant Professor of Family and Community Health;

Sarah A. McCarty, Assistant Professor of Medicine; Seyed N. Moussavian, Associate Professor of Medicine; Garry D. Brown, Assistant Professor of Pathology; John A. Hostler, Assistant Professor of Pediatrics; Michael E. Trulson, Associate Professor of Pharmacology, and James C. Harvey, Associate Professor of Surgery.

A needlepoint wall hanging was presented as a gift to the State Medical Association from its Auxiliary during the Association's Annual Meeting in August. Depicting all of the component auxiliaries of the State Auxiliary, the wall hanging was presented by Mrs. Gary G. Gilbert of Huntington, 1980-81 Auxiliary President, who coordinated the preparation of the gift. Each Auxiliary component designed and submitted a panel for the wall hanging, which was assembled in Huntington.

Computerized Medicare Processing Starts

Computers have touched virtually every segment of modern society. The processing of Medicare claims is no exception, according to Nationwide Insurance, the Part B Medicare carrier in West Virginia.

Nationwide is introducing a new electronic claims processing system for either *assigned* or *non-assigned* Medicare claims. The company is making a special commitment to encourage and assist physicians and suppliers to expand their use of electronic media claims billing systems.

Some of the major advantages of electronic media claims (EMC) billings, according to Nationwide, are:

- More timely processing of claims. Provides steady cash flow regardless of any carrier backlog conditions.
- Receipts of Medicare payments on a weekly basis rather than bi-weekly (every other week) payments.
- Eliminates possible misinterpretation of data by the carrier and the need to develop a claim for additional information.

Dr. Carl R. Adkins of Fayetteville (left) is administered the oath of office as new President of the State Medical Association by Dr. Harry Shannon, Parkersburg, the 1982-83 President, during the second and final session of the House of Delegates at the Association's Annual Meeting in August.

- Protects the integrity of profile data. Claims are entered directly into Nationwide's Medicare claims processing system using the codes as provided by the processing system using the codes as provided by the physician/supplier.
- Your patient account number will appear on the Explanation of Medicare Benefits, and on the monthly summary.
- Remittance reporting on assigned claims by means of magnetic tape, diskette, telecommunication or hardcopy printout. EMC monthly summary will be cross-referenced by Patient Medicare claim number to patient account number, and will reflect amount billed, allowed, date paid, and check number. A pending status report also is produced.
- Regulations permitting, opens the possibility of Electronic Funds Transfer in the future for EMC participants.
- Submission of claims with CPT-4 procedure codes.
- EMC claims eligible for supplementary coverage are transferred to the supplemental insurer on a more timely basis.
- Reduces postage expense.
- Relieves office of paperwork burden and minimizes collection of redundant information.
- Maximizes office staff time for professional activity and patient assistance, such as counseling.
- Once a participant in the EMC program, the biller has set the stage for future state of the art EMC enhancements.

Backlog in Medicare Claims

Nationwide Insurance Company-Medicare Operations said it is anticipating a sizeable backlog this coming year which will result in slower turnaround in claims payment. This backlog is expected to begin sometime this fall and continue through much, if not all, of calendar year 1984.

This backlog, Nationwide observed, will exist as a result of:

"1. Section 108 of the TEFRA regulations, effective October 1, 1983, resulting in the elimination of combined billing for hospital-based physicians. In projecting a 10-per cent increase in workload, we currently are hiring additional staff, but it will be some time before they are productive and able to absorb some of this additional workload.

"2. In late winter or early spring of 1984, we will be implementing a *totally new* claims proces-

sing system and simultaneously making two additional major changes: 1) introduction of a new Explanation of Medicare Benefits, and 2) implementation of a bi-weekly payment cycle and writing checks every other week.

"3. During the last half of calendar year 1984, we plan on converting to the Health Care Procedure Coding System (HCPCS) which incorporates *pure* CPT-4 procedure codes for all medical services.

Weekly Payments Continue

"These major activities will have a dramatic influence on our ability to handle any backlog situation. As discussed above, any physician or medical group submitting Medicare claims electronically will continue to be paid weekly, and both the assigned and non-assigned claims will bypass any backlog experienced by Nationwide during 1984."

The company said that physicians interested in avoiding these problems and maintaining cash flow to them and their patients while achieving the other benefits of Electronic Claims Submission should contact for more information: James A. Cuppy, Manager, Electronic Media Claims, Nationwide Insurance Company, P. O. Box 16781, Columbus, Ohio 43216. Telephone (614) 227-7059.

Charleston Laser Surgery Seminar December 10

A one-day Laser Surgery Seminar will be held on Saturday, December 10, at the Marriott Hotel in Charleston and The Eye and Ear Clinic of Charleston.

Subjects discussed during the morning session at the Marriott will include laser biophysics and applications, anesthesia in laser surgery, argon laser in retinal photocoagulation, helium-neon laser for pain relief, carbon dioxide laser in otolaryngology-head and neck surgery, carbon dioxide laser for acoustic tumor removal, Nd-YAG laser, and laser in gynecological surgery.

The afternoon session will consist of clinical demonstrations of carbon dioxide, argon and He-Ne lasers at The Eye and Ear Clinic, 1306 Kanawha Boulevard, East.

Guest Faculty

Members of the guest faculty will be Drs. Noel L. Cohen, Professor and Chairman of Otolaryngolgy-Head and Neck Surgery, New York University-Bellevue Medical Center, New York City; James F. Daniell, Assistant Professor, Obstetrics and Gynecology, Vanderbilt University, and N. LeRoy Lapp, Professor of Medicine and Chief of Pulmonary Medicine, West Virginia University Medical Center, Morgantown.

Four physicians and nine other medical personnel from the Charleston area also will serve on the faculty.

The seminar is sponsored by The Eye and Ear Clinic of Charleston; Department of Surgery, West Virginia University Medical Center, Charleston Division; and Charleston Area Medical Center.

The program has been approved for six hours of credit in Category 1 of the Physician's Recognition Award of the American Medical Association.

For additional information, contact Dr. Romeo Y. Lim at Box 2271, Charleston 25328. Telephone (304) 343-4371.

Elkins Doctor Visits China In Exchange Program

Dr. Harold L. Jellinek of Elkins was one of 34 physicians in the United States chosen to serve as a delegate in a bilateral exchange with Chinese physicians.

Doctor Jellinek, accompanied by Mrs. Jellinek, returned from the trip of approximately three weeks on October 17.

The exchange was conducted under the auspices of People to People International as part of its Citizen Ambassador Program, and was the result of an invitation by the Chinese Medical Association in conjunction with the Society of Renal Diseases of the People's Republic of China.

Doctor Jellinek is Chief of Cardiology at Memorial General Hospital and The Golden Clinic in Elkins.

Sports Champions Crowned At Annual Meeting

Dr. L. Dale Simmons of Clarksburg won the State Medical Association Golf Tournament trophy with the low gross score of 79 in annual competition held in conjunction with the Association's 116th Annual Meeting at the Greenbrier in August.

In tennis competition, limited to doubles play, Drs. Logan W. Hovis of Vienna and Harry A. Bishop of Clarksburg made up the winning team, with Dr. Alberto G. Capinpin of Charleston and

Mr. Ely J. Salon of Beckley second, and Drs. George E. Lovegrove of Columbia, South Carolina, and Maurice A. Mufson of Huntington third.

Mrs. Marcel G. Lambrechts of Charleston won the women's golf tournament (on the Old White course) with a low gross of 93. Winners in the women's tennis doubles competition were Mrs. James F. Williamson of Ashland, Kentucky, and Mrs. Prospero B. Gogo of Beckley.

Emergency, Ob-Gyn Groups Elect Officers

Officers recently were elected for state emergency physician and obstetrics-gynecology groups.

Dr. John S. Veach was named President Elect, and Dr. Ernest J. Bonitatibus, Vice President, of the West Virginia Chapter, American College of Emergency Physicians.

Doctor Veach, Assistant Professor of Surgery at the West Virginia University School of Medicine in Morgantown, is Medical Director of WVU Hospital's Emergency Department.

Doctor Bonitatibus, former Assistant Director of the Emergency Center of Wheeling Hospital.

Review A Book

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication.

Review of Medical Physiology, 11th Edition, by William F. Ganong, M. D. 643 pages. Price $20. Lange Medical Publications, Los Altos, California 94022. 1983.

Current Surgical Diagnosis and Treatment, 6th Edition, by Lawrence W. Way, M. D. 1,221 pages. Price $28. Lange Medical Publications, Los Altos, California 94022. 1983.

Basic and Clinical Endocrinology, edited by Francis S. Greenspan, M. D.; and Peter H. Forsham, M. D. 646 pages. Price $25. Lange Medical Publications, Los Altos, California 94022. 1983.

joined the WVU faculty in September as Instructor in Surgery and staff physician in WVU Hospital's Emergency Department.

Doctor Daniel A. Mairs of Charleston was elected to a three-year term, beginning in September, as Chairman of the West Virginia Section of the American College of Obstetricians and Gynecologists. In private practice in Charleston, Doctor Mairs is affiliated with Charleston Area Medical Center and St. Francis Hospital. He is a WVU Clinical Professor of Obstetrics and Gynecology.

Marshall Doctor On Committee For Licensing Tests

Dr. Donald S. Robinson of the Marshall University School of Medicine has been named to a national committee developing simulated patient cases for medical licensing tests of the National Board of Medical Examiners.

"The National Board is planning to use computer 'patients' to help test clinical decision-making and problem-solving skills," said Doctor Robinson, Professor and Chairman of Pharmacology and Professor of Psychiatry and Medicine.

"This is a whole new concept in competency testing for doctors," he said. "The good thing about it is that it more closely approximates real life than any pencil-and-paper test can.

"The person taking the test will actually interact with the computer, asking questions about symptoms and physical exam findings, as well as requesting lab tests," he explained.

MU Physician Practice Group Medical Director Named

Timothy G. Saxe, M. D., has become the new Medical Director of John Marshall Medical Services, according to Dr. Robert W. Coon, M. D., Dean of the Marshall University School of Medicine, and John M. Zink, JMMS Executive Director.

John Marshall Medical Services is the physician practice group of the MU School of Medicine.

Doctor Saxe, formerly of Morgantown, previously served as a staff internist at Eglin Regional Hospital on Eglin Air Force Base, Florida. He also served as Chief of Internal Medicine at the U.S. Air Force Hospital at

Moody Air Force Base in Georgia from 1980 to 1982, and was a consulting internist at a Lakeland, Georgia, hospital during this period as well.

Doctor Saxe earned his M. D. degree from West Virginia University in 1977, and served his residency at Charleston Area Medical Center.

Forum On Air Toxics Planned In South Charleston

A forum on toxic air pollutants will be sponsored Tuesday, November 15, at the Ramada Inn in South Charleston by the Air Pollution Control Association, East Central Section.

The public is encouraged to attend.

Speakers will discuss air toxics regulations, measurement, control and health effects.

Attendees will participate in an afternoon panel discussion with representatives of the U. S. Environmental Protection Agency, Chemical Manufacturer's Association and Natural Resources Defense Council.

A luncheon address on directions of air toxics control in West Virginia will be presented by C. G. Beard II, Director, West Virginia Air Pollution Control Commission.

More details are available from the Air Pollution Control Association, P. O. Box 2861, Pittsburgh, Pennsylvania 15230.

Drug, Alcohol Abuse Shows On PBS November 2, 9

Medical societies and physicians have been urged by the American Medical Association Department of Health and Human Behavior to view and discuss "The Chemical People," a two-part television program aimed at promoting awareness of drug and alcohol abuse by children and adolescents.

More than 200 Public Broadcasting Service stations across the country will air the programs on November 2 and 9. In many areas, the PBS stations and volunteer groups are organizing town meetings to view the first broadcast and discuss how it relates to local situations. Participants will be invited to return the following week to watch the second broadcast, which shows how ongoing task forces can be created to spur community-wide prevention, education, and treatment efforts.

Medical Meetings

Nov. 6-9—Scientific Assembly, Southern Medical Assoc., Baltimore.

Nov. 7-9—Am. Medical Women's Assoc., Dearborn, MI.

Nov. 15—Toxic Air Pollutants (Air Pollution Control Assoc., East Central Section, Pittsburgh), South Charleston.

Dec. 3-6 — Am. Society of Hematology, San Francisco.

Dec. 4-7 — Interim Meeting, AMA House, Los Angeles.

Dec. 10—Laser Surgery Seminar (Eye & Ear Clinic of Charleston; Dept. of Surgery, WVU Medical Center, Charleston Division; and Charleston Area Medical Center), Charleston.

1984

Jan. 19-21—Neurosurgical Society of the Virginias, Williamsburg, VA.

Jan. 27-29—17th Mid-Winter Clinical Conference, Charleston.

Feb. 9-14—Am. Academy of Orthopaedic Surgeons, Atlanta.

Feb. 12-15—W. Va. Perinatal Assoc., Snowshoe.

Feb. 15-19—Am. College of Nuclear Physicians.

Feb. 16-17—AIDS (Drug Development Institute of Am., Colts Neck, NJ), New York City.

March 3-7—Am. Academy of Allergy & Immunology, Chicago.

March 17—Annual Meeting, W. Va. Affiliate, American Diabetes Assoc., Wheeling.

March 25-29—Am. College of Cardiology, Dallas.

March 30-April 1 — Neurological Diseases Seminar (United Hospital Center), Clarksburg.

April 6-8—WV Chapter, AAFP, Charleston.

April 8-14—Am. Academy of Neurology, Boston.

April 9-13—Am. Roentgen Ray Society, Las Vegas.

May 2-5—W. Va. Chapter, Am. College of Surgeons; and W. Va. Otolaryngological Society, White Sulphur Springs.

May 6-9—Am. Urological Assoc., New Orleans.

May 7-9 — Am. Assoc. for Thoracic Surgery, New York City.

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WVU Medical Center
–News–

Compiled from material furnished by the Medical Center News Service, Morgantown, W. Va.

Laser, Ultrasound Lessen Neurosurgery Risks

Certain tumors of the brain or spinal cord, formerly accessible only by disturbing and sometimes damaging other vital tissues, are being removed at WVU Hospital by two innovative techniques.

G. Robert Nugent, M. D., Professor and Chairman of Neurosurgery, said use of laser beams and ultrasound should lessen risk for the patient.

"These procedures should improve overall results," he explained. "We are able to remove a tumor in a difficult area with less chance of neurologic deficits."

Doctor Nugent explained that patients undergoing surgery are always told of possible residual effects such as loss of hearing in one ear, paralysis of the face, paralysis of the opposite side of the body or loss of speech. In spinal cord surgery, possible complications are paraplegia and loss of bowel, bladder or sexual function.

Tumor Vaporized

These risks are inherent in conventional surgery because of the necessity of manipulating surrounding tissues to reach deep-seated tumors.

Doctor Nugent described the laser procedure as a "no-touch technique which reaches the tumor from afar."

"We vaporize the tumor," he said. "It literally goes up in smoke."

In addition to its advantages in reaching deep-seated areas, the laser technique also reduces blood loss in some tumors because vessels are coagulated. It also sterilizes the operation field, Doctor Nugent said.

"It's an excellent procedure for certain specific kinds of tumors—those that are surrounded by vital structures and are hard to remove," he explained.

The ultrasound procedure is used mainly for tumors of the spinal cord, Doctor Nugent said. Known as a Cavitron Ultrasonic Surgical Aspirator (CUSA), the hand-held probe fragments tumors by bombarding them with high-frequency sound wave vibrations of 23,000 cycles per second. At the same time, the area is irrigated and the fluid and tumor pieces removed by suction.

"The tumor just disappears and there is no harm to surrounding tissues," Doctor Nugent said.

Although the laser may have some use in spinal cord surgery, he prefers to use the CUSA. "One false move and the laser could vaporize the spinal cord," he remarked.

Genetics Center Adding Two Statewide Programs

The West Virginia Genetics Center, already one of the largest and most successful outreach programs of the WVU Medical Center, will expand its activities during the coming year.

R. Stephen Amato, M. D., Professor of Pediatrics and Director of Medical Genetics, said two new statewide programs are now being implemented.

One will focus on the extension of interdisciplinary evaluation capability to the six satellite clinics. The second will provide health professionals with in-service training in the early recognition of birth defects.

Doctor Amato said the interdisciplinary service is being funded by a federal grant from the Department of Health and Human Services for $160,000 a year for three years. This grant will be used to establish and operate a model program to provide educational, psychological and full developmental evaluations for children and adults who have handicapping conditions.

The in-service training program, which will encompass all areas of the state, will give the new personnel an opportunity to meet health professionals.

"We're planning to have educational programs in every hospital that delivers babies as well as with nursing groups and state health and family planning clinics," Doctor Amato said.

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Third-Party News, Views and Program Concerns

Doctors' Stake In PROs Aired By AMA Head, Senator

Local physicians' support is vital to the success of peer review organizations, American Medical Association Executive Vice President James H. Sammons, M. D., said in comments concerning a proposed federal regulation. The proposed rule would provide that a peer review organization must be composed of at least five per cent of the area's licensed practicing physicians.

In his comments, Doctor Sammons recommended that the minimum percentage of physicians should be established as 25 per cent to guarantee adequate physician support. Further, the PRO should represent physicians of all specialties throughout the geographic region it serves, Doctor Sammons said.

Doctor Representation Important

"During the contract evaluation process, HCFA [Health Care Financing Administration] should give priority to the physician-sponsored organization composed of the greatest percentage of the area's physicians," Doctor Sammons said.

The proposal to require a physician-access PRO—as distinguished from a physician-organization PRO or a payor PRO—to have at least one physician in every recognized specialty is insufficient to assure adequate peer review, Doctor Sammons said in a letter to Philip Nathanson, Director of the Health Standards and Quality Bureau, HCFA. Modifying the proposal to require that physician-access organizations have a geographic balance of area physicians directly engaged in patient care would greatly increase the chances of local physician acceptance, he said.

Contract Should Go To Non-Payor Group

The AMA believes that a non-payor organization that submits an acceptable plan should be awarded the PRO contract over any payor organization, Doctor Sammons told HCFA.

Meanwhile, during a recent AMA conference on PROs and Prospective Payment in Washington, D. C., Sen. David Durenberger (R, Minn.) said the new peer review legislation provides the last opportunity for physicians to have a significant role in medical review. "The Reagan Administration still wants review to be conducted by fiscal intermediaries. And organized medicine has been extraordinarily slow in recognizing that the choice is not between peer review and nothing at all. If you don't do it, an insurance company employee will," Durenberger told the AMA conference.

Who Else But Physicians?

"Who else but physicians can assess the quality and quantity of medical care?," the author of the PRO legislation asked. "Who else knows when a complicated case merits further treatment? Who else but physicians can tell us when a patient has been discharged too early? We cannot let insurance company employees make these decisions."

Moving to the topic of prospective payment, Durenberger said that a number of legislators have expressed interest in the idea of using diagnosis-related groups for reimbursing physicians as well as hospitals. The HCFA is beginning to compute physician charges by DRGs, he said. "You can expect that as soon as the data are available, physicians will be included in the prospective payment system."

Lump Sum Payment

"I foresee inclusion of a physician payment into each hospital DRG. Thus, there would be one lump sum payment to be shared by the physician and the hospital. That payment would not necessarily have to be made to the hospital. In fact, if a physician-sponsored organization were willing to accept the entire payment and contract with hospitals for institutional services, all the better. After all, it's physicians—not hospitals—who manage patient care," Durenberger said.

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Obituaries

S. ELIZABETH McFETRIDGE, M. D.

Dr. S. Elizabeth McFetridge of Shepherdstown, a general practitioner and anesthesiologist, died on September 1 in a hospital there. She was 82.

Doctor McFetridge was the first woman elected President of the Eastern Panhandle Medical Society (1948), and served twice on the Council of the State Medical Association (1958-62 and 1966-70).

She was a Past President of the American Cancer Society, West Virginia Division, serving on its Board of Directors for 27 years.

Doctor McFetridge was born in Belmont County, Ohio. She was graduated from Muskingum College in New Concord, Ohio, and taught science and mathematics for one year in Stewartsville, Ohio. She then entered the former two-year West Virginia University School of Medicine, graduating in 1927 as the only girl in her class.

Doctor McFetridge received her M. D. degree in 1930 from Rush Medical College in Chicago, and interned at Swedish Covenant and Presbyterian hospitals in that city. She then worked in the Anesthesia Department of the University of Chicago Clinics at Billings Hospital from 1930 to 1933.

In 1933, she and her husband, the late Dr. Halvard Wanger, moved to Shepherdstown, where she practiced anesthesiology until the beginning of World War II.

Because of the scarcity of local doctors during the war, Doctor McFetridge found her professional role expanding to home deliveries and hospital emergency room duties. She also assisted the Shepherdstown Volunteer Fire Department during the war, and later was honored by being made a member (1963). She was given a surprise party by the Fire Department on her 80th birthday in recognition of her service.

Doctor McFetridge was a Fellow of the American College of Anesthesiology and the International College of Anesthesia and Analgesia, and an honorary member of the Eastern Panhandle Medical Society, West Virginia State Medical Association and American Medical Association.

Survivors include two sons, Drs. William H. Wanger of Bluefield and H. Alexander Wanger of Martinsburg; two daughters, Brita Elizabeth Wanger of Reidsville, North Carolina, and Mrs. Joseph Selove of Herndon, Virginia, and a sister, Mary Reid Wilson of St. Clairsville, Ohio.

* * *

JOHN P. YOUNG, JR., M. D.

Dr. John P. Young, Jr., surgeon in Wheeling since 1949, died on September 8 in a hospital there. He was 67.

Born in Salem, Doctor Young was graduated from West Virginia University, and received his M. D. degree in 1942 from Rush Medical College in Chicago. He interned at St. Luke's Hospital in Chicago, and completed his residency at the University of Illinois.

Doctor Young was given an honorary degree from the Sigma Zi National Scientific Fraternity for his work with penicillin during World War II.

He was a charter member of the Warren H. Cole Surgical Society; a Diplomate of the American Board of Surgery; a Fellow of the American College of Surgeons, and a member of the Surgical Society of Wheeling, Ohio County Medical Society and West Virginia State Medical Association.

Survivors include the widow; two daughters, Mrs. Larry Dodd and Betsy Young, both of Wheeling; one son, John P. Young III of Wheeling; one brother, Dr. James E. Young of Brownsville, Tennessee, and three sisters, Mrs. Eleanor DeTurk of Henryetta, Oklahoma; Mrs. Ann Martin of Frederick, Maryland, and Mrs. Barbara Stanton of Fairborne, Ohio.

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County Societies

FAYETTE

The Fayette County Medical Society met on September 7 in Oak Hill at the Plateau Medical Center.

The guest speaker was Dr. M. Khalid Hasan, Beckley psychiatrist, whose topic was "Management of Depression."—Serafino S. Maducdoc, Jr., M. D. Secretary.

* * *

CABELL

Eric W. Springer, Pittsburgh attorney who is a lecturer and writer in the field of health and hospital law, was the guest speaker for the meeting of the Cabell County Medical Society on September 8.

His talk concluded a day-long symposium on credentialing sponsored by the Society, Cabell-Huntington Hospital, St. Mary's Hospital and Marshall University School of Medicine. — S. Kenneth Wolfe, M. D., Secretary.

* * *

McDOWELL

The McDowell County Medical Society met on September 14 at Stevens Clinic Hospital in Welch.

The Society approved a resolution stating the need for additional internists and primary care physicians in McDowell County.—John S. Cook, M. D., Secretary.

* * *

WESTERN

A program on surgical laser systems was presented for the meeting of the Western Medical Society on September 13 in Spencer. The speaker was Roger Portaro, representative of the Paul Rogers Company of Cincinnati.

Dr. James T. Hughes of Ripley, a Society Delegate to the 116th Annual Meeting of the State Medical Association in August in White Sulphur Springs, gave a report on the convention.—Ali H. Morad, M. D., Secretary-Treasurer.

CHANGE OF ADDRESS

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. The 1984 Roster of Members will be prepared and placed in the mails shortly after the first of the year and we would very much like for your correct address to appear in same. If applicable, to comply with recent U. S. Postal Service regulations, please include your P. O. Box number with zip code. Changes should be mailed to Box 1031, Charleston, West Virginia 25324.

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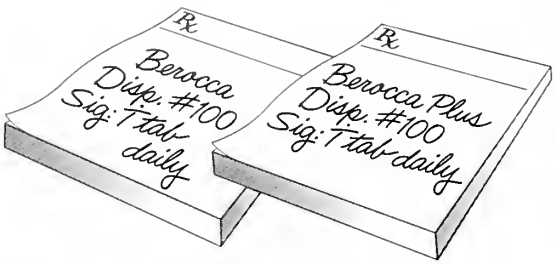

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I certify that the statements made by me above are correct and complete.

(Signed) Charles R. Lewis,
Managing Editor

The West Virginia Medical Journal

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Limb Preservation In Extremity Osteosarcoma

ERIC T. JONES, M. D., Ph.D.
Associate Professor of Orthopedic Surgery, West Virginia University Medical Center, Morgantown

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Limb salvage is an alternative to amputation in many patients with extremity osteosarcoma. At West Virginia University we have found that limb salvage is best completed with a two-surgeon approach. One surgeon removes the tumor with concern only for adequate resection margin. The second surgeon is then concerned with reconstruction. Early tumor recognition and early treatment not only increase survival but also the probability that a tumor will be amenable to limb salvage.

The survival of children with extremity osteogenic sarcoma was for many years static at approximately 10-per cent, five-year survival. By contrast, the past 10 years have seen such a change in expected survival that more than half can expect to be alive five years after initial treatment. Surgical treatment for osteogenic sarcoma (i.e., removal of a tumor) has always been the "sine qua non" for curative therapy. Classically, "surgical" treatment meant extremity amputation. In the past 10 years, however, surgical alternatives that preserve a useful extremity have evolved.

During the 1970s, there was considerable enthusiasm about increased survival of patients with osteosarcoma. This apparent improvement was attributed to chemotherapy, but all chemotherapy protocols gave equivalent results: about 50-per cent, five-year survival. Recent reports have cast doubt on the role of chemotherapy by showing 50-per cent survival with surgical treatment alone. Studies currently under way are aimed at comparing surgery alone with surgery plus various chemotherapy regimens. Statistically-valid results are not expected for several years.

While there is agreement about surgical removal as the mainstay of therapy for this malignancy, there is no shortage of controversy as to how removal should be accomplished. Some surgeons still perform "whole bone" amputations in the belief that the likelihood of occult "skip lesions" warrant this type of procedure. Most surgeons attempt to do the resection at least seven to ten cm. away from the tumor (as shown by plain radiograph, CT and nuclear imaging). In the femur, this usually means a high-thigh amputation. While a short above-knee stump is functionally difficult, it certainly is more functional than a hip disarticulation. The local recurrence risk with this "across-the-bone" amputation is less than five per cent.

In about 50 per cent of cases, it is possible to have adequate resection margins for an "across-the-bone" amputation and still preserve an extremity that is at least as functional as an external prosthesis at the same level. In these cases it is necessary to substitute an "internal" prosthesis for the resected bone and joint elements.

During 1982, five patients with osteogenic sarcoma presented to the Pediatric Orthopedic Section at WVU. Three lesions were in the distal femur, one in the proximal femur, and one in the proximal tibia. Two patients had high-thigh amputations, two had segmental resection with prosthetic replacement, and one had local resection and reconstruction with autogenous bone (Figure 1). It is, of course, too early and the series too small to make statistical comparisons, but the case reports of these patients are included.

Case One

A 13-year-old boy presented to his local physician in January, 1982, with a six-month history of knee pain. A large destructive lesion was demonstrated in the proximal tibial metaphysis. Biopsy proved this an osteogenic sarcoma. A distal femoral amputation was elected as there was involvement of the quadriceps insertion and tibial neurovascular bundle.

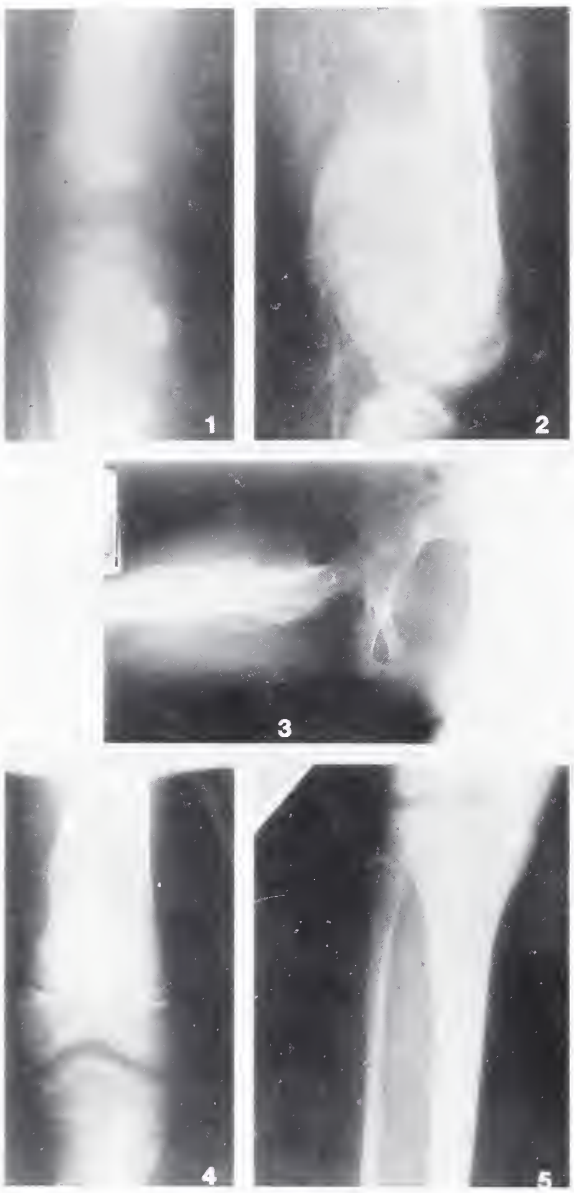

Figure 1. The osteogenic sarcoma patients seen within the last year in West Virginia University are shown above. For detailed case reports of each, refer to the text. Case 1 shows a destructive lesion in the proximal tibia. Case 2 shows the venous phase of an arteriogram in a boy with a large distal femoral lesion. Case 3 illustrates the recurrent aggressive lesion in the proximal femur. Case 4 illustrates the lytic destructive lesion in the left distal medial femur. Case 5 shows a parosteal type lesion in the proximal tibia.

The patient at one and one half years post-surgery has no evidence of metastatic disease, and uses an above-knee prothesis well.

Case Two

A 16-year-old boy presented to his local orthopedist for evaluation of knee pain in November of 1981. Radiographs were taken at that time and were believed to be normal, so the patient was placed on an exercise program. He returned in March of 1982, however, with a large mass in the distal right femur, which on biopsy proved to be an osteogenic sarcoma. This mass involved the distal femoral blood vessels and tibial nerve in such a way that reconstruction was not thought possible. The patient had a high-thigh, across-bone amputation, and was found in the immediate post-amputation period to have a metastatic nodule in the right upper lobe of his lung. This was excised surgically.

The patient, at 19 months after excision of his tumors from limb and lung, showed no further evidence of metastatic disease, and currently is on a chemotherapy program. He uses crutches most of the time, and only occasionally uses his above-knee prosthesis.

Case Three

A 12-year-old girl was found to have a lesion in the proximal femur on an abdominal radiograph taken for abdominal pain. This lesion was excised, and biopsy indicated that it was benign. Four months later, following complaints of a mass and progressive pain, radiographs revealed that the patient had had recurrence of tumor in the same area, and she was admitted to West Virginia University for evaluation. A rebiopsy of this area showed osteogenic sarcoma, and she subsequently had local resection of this lesion.

Her limb, which had been salvaged by local tumor removal, was reconstructed by replacement of her proximal femur with a custom total hip prosthesis (Figure 2). She is currently ambulatory with no assistive device other than a knee brace. She is one year post-excision and has shown no evidence of metastatic disease.

Case Four

A 12-year-old boy complained to his local physician of knee pain. When radiographs revealed a lytic lesion in his left distal medial femur, he was referred to his local orthopedic surgeon, who referred him to West Virginia University. At WVU he had biopsy of this lesion, which proved to be an osteogenic sarcoma. He

underwent excision of this lesion within two weeks of the time that the lesion was first detected by his local physician, and subsequently he had reconstruction of his distal femur and knee joint (Figure 3).

One year following distal femoral replacement and total knee arthroplasty, and undergoing chemotherapy, he showed no evidence of metastatic disease, and was ambulatory without any assistive device.

Case Five

A 14-year-old girl presented to her local family physician with complaints of leg pain; radiographs revealed a lesion in the proximal tibia. Biopsy showed an osteogenic sarcoma that was of an unusual cell type believed to be amenable to radiation therapy. Radiation treatment decreased the size of the lesion so that local resection and reconstruction were possible. Prior to radiation treatment, a through-the-knee amputation would have been required as the lesion was immediately adjacent to both the peroneal and tibial nerves.

Figure 2. The patient detailed in Case 3 following resection of her proximal femur and quadriceps musculature and prosthetic replacement with a long proximal femoral replacement. She now walks with only a brace to help lock her knee in extension.

Rationale of Limb Salvage

There are many factors which must be considered in determining whether limb salvage or amputation is indicated. The basic principle is that all tumors must be surgically removed and then, if the quality of the limb which remains is better than an external prosthesis, the limb is reconstructed (Figure 2).

Refusal to have an amputation is rarely, if ever, an indication for a salvage operation. Occasionally, a limb that is insensate or not functional will have to be unablated if the family "refuses" amputation. Amputation can then be done at a later date, when the patient is convinced a limb is nonfunctional.

Age at presentation of less than 10 years with a lower extremity osteosarcoma may be a relative contraindication to a limb preservation procedure. With the considerable amount of growth remaining, there will need to be several revisions or limb lengthenings to maintain limb lengths that are nearly equivalent. However, joint reconstruction in these children, when it is feasible, can be done if the surgeon and family recognize that, if the child survives very many years, several revisions may be required or later amputation can be done.

The presence or absence of metastatic disease probably should not determine whether or not a limb salvage procedure is appropriate. A patient who will only survive a few years due to metastatic disease will, in fact, do very well with a limb salvage procedure because the chance of prosthetic loosening during the patient's shortened lifetime would be minimal.

Another Viewpoint

However, it also is argued that, because amputation surgery is "more predictable," there are fewer problems, and the patient may be able to be out of the hospital more of the time than with a limb salvage procedure. Some authors have indicated that the grade of the sarcoma (a highly anaplastic lesion or a very low grade lesion) should be an indicator for limb salvage.

This too is not a relative consideration because the basic principle is to excise all of the tumor, no matter what the grade.

Obviously, the smaller the lesion, the more amenable it is to local resection and reconstruction. Larger lesions are more likely to involve important neurovascular structures that would, then, have to be removed with the malignancy. This could render the salvaged limb less useful than an amputation. Computerized tomography has been found very useful in helping to predict the soft tissue extent of extremity osteosarcoma and also, possibly more importantly, in helping to determine the intramedullary extent of the tumor. With the trend toward limb salvage procedures, the CT scan has been of great utility in outlining the lesion and its relationship to neurovascular structures.

Figure 3. This replacement was done for a distal femoral osteogenic sarcoma. This boy had replacement of his distal femur and knee joint with excision only of a small portion of his quadriceps muscle. He now walks with no assistive device (Case 4).

The CT scan, however, should not be used alone, but as an adjunctive study because of the possibility of over- and under-interpretations. (Interpretation is limited by the density difference between the tumor and surroundng structures.) Nevertheless, the CT scan is very good for determining the extent of the lesion inside bone. Thus it is of great help in determining amputation level.

Two-Surgeon Technique

At West Virginia University, we have found it very useful to involve two surgeons in the process of limb salvage. One surgeon (with specialty interest and training in tumor surgery) concentrates on removing the tumor, while the second (whose specialty interest and training are prosthetic reconstruction) designs and reconstructs the bone and/or joint that has been removed. This approach allows the tumor surgeon to concentrate only on what he needs to do to remove the tumor entirely, with minimal consideration given to reconstruction.

Currently, we remove the tumor in one operation and then have the patient remain in traction (either in the hospital or at home) until a prosthesis is fabricated to replace resected tissue. Once it has been determined by the pathologist that there has been adequate resection of tumor, subsequent reconstructive surgery is then carried out.

Limb salvage may increase the risk of local recurrence; however, we feel that using two surgeons and two separate surgical procedures helps assure generous resection margins and the best possible reconstruction.

(At some centers, the prosthesis is designed based on pre-resection radiographs. The tumor operation is then delayed until the prosthesis is available—usually about six weeks—and there is little leeway for the tumor surgeon in tumor resection.)

Current Treatment Standards

We believe that one of the major reasons for improved survival in extremity osteosarcoma is earlier presentation to a primary physician with a short course of extremity (usually knee) pain.

Early examination, including x-rays, leads to earlier referral for biopsy and surgical excision. Earlier removal of a tumor lessens the incidence of fatal metastatic disease.

The biopsy site for these lesions should be chosen with great care as this site must later be removed as part of the excisional treatment. A poorly placed biopsy site or a site not chosen with reconstruction in mind can eliminate limb preservation as a possibility.

Biopsy and excision of the tumor are not emergent procedures, but they are urgent procedures. All preoperative studies should be obtained in an expeditious but complete manner so that excision of the lesion can be accomplished as soon as possible. The longer the time from recognition to actual surgical amputation, the longer the time available for metastatic disease to develop.

Conclusion

It was not long ago that all children presenting with distal femoral osteogenic sarcoma would have a high-thigh amputation or hip disarticulation procedure, and less than 20 per cent would be alive five years later. In 1983, over 50 per cent of children with osteogenic sarcoma will not have an amputation at all, and over 50 per cent can expect to be alive five years later.

The reasons for the dramatic improvement in these statistics remain somewhat obscure. However, the principle of treatment from a surgical perspective remains clear: excise the tumor completely and as quickly as possible. By maintaining a high index of suspicion, physicians can refer patients for definitive diagnosis and treatment earlier. As patients are treated earlier, we expect that both survival and the possibility of limb preservation will improve.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (no onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing the most commonly known trade-name drug of that designation. In addition, a listing of all generic drugs mentioned in the article, with their trade-name equivalents, should appear at the end of the article.

A short abstract summarizing the manuscript should be included. This should be typed in double space on a separate page.

Authors are requested to submit a carbon copy with the original.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for reproduction should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. Cost of printing black and white photos in excess of 4 will be billed to author, and no more than 25 references will be published free of charge to the author. A legend should be provided for each illustration and, preferably, attached to it.

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1983 Van Liere Memorial Student Research Convocation, WVU School Of Medicine

The 1983 Van Liere Memorial Research Convocation for students in the West Virginia University School of Medicine was held on April 7. These yearly convocations enable students in the School of Medicine to present the results of their research activities in competition for the Edward J. Van Liere Award.

This award consisting of a plaque and a check for $200, was established by action of the faculty of the School of Medicine to recognize the research efforts of our students and to honor the late Dr. Edward J. Van Liere, who served as Chairman of the Department of Physiology from 1921 - 1955 and as Dean of the School of Medicine from 1935-1961.

Twelve students participated in the 1983 Research Convocation, which was the nineteenth one in the series. Two of these students were ineligible to compete for the Van Liere Award because they presented data from research done in partial fulfillment of the requirements for a Ph.D. degree. But they did compete for prize money equal in value to the monetary award associated with the Van Liere Award competition.

The winner of the Van Liere Award this year was David J. Brailer, a second-year student. The first runner-up and winner of a check for $100 was Ted Thornton, also a second-year student; the second runner-up and winner of a check for $50 was Robert R. Johnson II, a first-year student. In addition, the two students who were ineligible to compete for the Van Liere Award were awarded prizes. John Schulz and Walter C. Brogan III, both first-year students, received prizes of $200 and $100, respectively.

The publication of the abstracts of the winning oral presentations in *The West Virginina Medical Journal* constitutes an important and greatly appreciated recognition of the research efforts of our students.

W. E. Gladfelter, Ph.D.
Chairman, Van Liere Memorial
Research Convocation Committee

Statistical Image Modulation, Detection And Analysis Of Dynamic Video-Digitizations Of Hepatic Microvasculature

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This study is part of an investigation into the feasibility of using a microcomputer to calculate volumetric rate of blood flow in microvessels on-line from measurement of internal diameter and red cell velocity. Presently, this is not easily done because internal diameter (ID) measurements must be made manually by shearing the video image while red cell velocity is automatically tracked.

The purpose of this investigation was to use video tapes of hepatic microvasculature to develop a method to measure ID that could then be adapted for on-line measurements.

Computerized edge detection methods initially were tried to distinguish *in vivo* between vasculature and nonvasculature by determining the walls of the microvasculature. However, the tremendous variability in microvascular geometry, the absence of prominent microvascular borders, and the rigid process algorithm, made edge detection an unadaptable approach. As a result, a statistical image analysis technique was developed and determined to be reliable for identification of borders of these microvessels. This method relies only on a comparison of the change in the density (grey-levels) of corresponding pixels obtained from two video frames digitized a short time apart (one fifteenth to one fifth second).

Algorithm Used

This comparison is done using a statistical decision-making algorithm to reduce the complex density pattern of microvessels, hepatocytes, etc. in the digitized video images to simply a determination of the percentage of pixels which change density from one frame to the next due to red cell movement. Regions where large changes occur are representative of vasculature containing blood flow and serve to identify borders with nonperfused regions. These borders then can be used to calculate intravascular diameters.

The further development of this rapid, full-field method of analysis to distinguish the microcirculation should provide a more convenient approach to on-line measurements ID of microvessels with flow.

Study Of Estrogen-Specific Growth Of Male Accessory Sex Organ Smooth Muscle Using A Novel Anti-Estrogen

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HUMAN BPH, which consists primarily of fibromuscular tissue, develops at least in part from the stimulatory actions of estrogen. Within male accessory sex organs, it is known that smooth muscle is the target tissue for estrogen, and that this muscle contains high concentrations of estrogen binding proteins (EBPs). However, no direct relationship has been established between these EBPs and estrogenic action.

Insight into the functional significance of these EBPs may be obtained through the appropriate use of an anti-estrogen, particularly the newly developed anti-estrogen LY-117018 (Eli Lilly), because of its unique lack of intrinsic estrogenic activity.

Using the surgically prepared guinea pig seminal vesicle smooth muscle, *in vitro* analyses revealed that LY-117018 was a highly effective competitor for the estrogen-EBP interaction. The relative order of competitor affinity for the EBPs was E_2 = LY-117018 >> DHT > cyproterone acetate. In contrast, LY-117018 had virtually no effect on the *in vitro* binding of H^3-DHT to seminal vesicle muscle (SVM) or epithelium (SVE) androgen binding proteins.

Daily Injections

Analyzing the *in vivo* anti-estrogenic actions of LY-117018 involved daily injecions of castrated guinea pigs for four weeks with LY-117018 alone and in combination with either estradiol benzoate or dihydrotestosterone, and measuring seminal vesicle muscle weight, RNA content, DNA content, and collagen content. LY-117018 proved to be specific anti-estrogen with no intrinsic estrogenic activity. That is, LY-117018 significantly inhibited estrogenic induction of all parameters measured, while LY-117018 alone had no anabolic effects. In addition, LY-117018 had no significant effect on androgen-induced growth of either the SVM or SVE.

In summary, these findings suggest that the muscle EBPs represent a functional estrogen receptor. In addition, the drug LY-117018 was found to be a potent and specific anti-estrogen with no intrinsic estrogenic activity, properties which ultimately may make it of use in the non-surgical treatment of BPH.

Growth Of Human Breast Carcinoma Cells: An Analysis By Microinjection Of Proteins

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It has been demonstrated that increased levels of intracellular cAMP are present during cell growth arrest in the G_1 phase of the cell cycle in many cell lines. The only established role of cAMP in eucaryotic cells is to activate cAMP-dependent protein kinase where four molecules of cAMP cause dissociation of one protein kinase holoenzyme into two regulatory subunits and two active catalytic subunits.

Our working hypothesis was that the catalytic subunit of cAMP-dependent protein kinase was the actual effector of growth inhibition in human breast carcinoma cells (cell line MCF-7). This hypothesis was tested by using chicken erythrocytes to microinject the catalytic subunit of protein kinase directly into individual human breast carcinoma cells. The erythrocytes were prepared by lysing them to remove the endogenous proteins; addition of the exogenous proteins: catalytic subunit, bovine serum albumin (BSA) or catalytic subunit inactivated by N-ethylmaleimide (C + NEM); followed by dialysis in a hypertonic solution to reseal the erythrocytes, thus encapsulating the proteins within the erythrocyte ghosts.

Ghosts Lysed and Centrifuged

A sample of ghosts from each condition was lysed and centrifuged to pellet the erythrocyte membranes, and the resulting cytosolic supernatant was assayed for protein kinase activity so that the amount of kinase activity encapsulated per ghost could be calculated for each condition.

Erythrocyte concentration was used to determine the amount of ghosts necessary to microinject 50 per cent of the MCF-7 cells. Cells not microinjected served as internal controls. The erythrocyte ghosts were overlaid onto MCF-7 cells actively growing on cover slips along with phytohemmaglutinin to attach the ghosts to the MCF-7 cell membranes. Fusion was facilitated by polyethylene glycol which resulted in the microinjection of the exogenous proteins and nucleus of the erythrocyte ghost into the MCF-7 cytoplasm.

A chicken erythrocyte nucleus in the MCF-7 cytoplasm served as a marker for a successful microinjection event. The resulting MCF-7/ghost product was then overlaid with growth media containing ^{3}H-thymidine to monitor entry into the S-phase, which is the DNA-synthesizing phase of the cell cycle. At specified time points, duplicate cover slips of MCF-7 cells were removed, fixed and subjected to autoradiography. The cells were analyzed for microinjection events and entry into the S-phase. Entry into the S-phase was determined by the presence of a labelled MCF-7 nucleus (i.e., exposed silver grains above the nucleus) which indicated incorporation of ^{3}H-thymidine into the MCF-7 DNA.

Cell Growth Determination

Cell growth was determined by graphing percent-labelled MCF-7 nuclei as a function of time. Percent-labelled nuclei of microinjected cells was compared to percent-labelled nuclei of non-microinjected cells to determine if cell growth inhibition occurred due to microinjection of catalytic subunit.

If our hypothesis was correct, only cells microinjected with active catalytic subunit should exhibit cell growth inhibition. The results showed that active catalytic subunit did not cause cell growth inhibition when compared to the control proteins: BSA or C + NEM. There was some decreased cell growth due to the microinjection event itself as evidenced by the decreased cell growth of all three microinjected proteins compared to their respective non-microinjected internal controls.

Subunit Alone Not a Key Regulator

Our conclusion was that active catalytic subunit alone is not a key regulator of cell growth in human breast cell carcinoma. However, the lack of this effect may be due to rapid inactivation or degradation of the microinjected catalytic subunit within the MCF-7 cytoplasm.

The cAMP inhibitory effect seen in this cell line could be due to toxic metabolic products, or, as proposed by others, the undissociated cAMP-protein kinase complex may be translocated into the nucleus and affect gene expression.

Effects Of Ouabain, Histamine And Isoproterenol On Electrophysiological Parameters Of Control And Supersensitive Cells Of The Guinea Pig Sinoatrial Node

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SUPERSENSITIVITY is defined as the phenomenon in which the amount of a substance required to produce a given biological response is less than normal. In other words, there is a shift to the left in the dose-response curve, with or without a change in maximum response. Postjunctional supersensitivity develops following chronic interruption of the nervous input to an effector cell, such as that produced by chronic depletion of catecholamines with reserpine. One of the mechanisms implicated in the production of this phenomenon, a reduction in electrogenic sodium pumping, has been demonstrated in supersensitive guinea pig vas deferens.

Experiments were designed to determine the contribution of the electrogenic sodium pump to the electrical activity of pacemaker cells of the guinea pig sinoatrial node. In particular, studies were performed to assess if an alteration in pump activity might explain the catecholamine-specific chronotropic supersensitivity which develops in this tissue following seven days of pretreatment with reserpine (0.1 mg/kg/day i.p.).

Electrical Activity Measured

The electrical activity of sinoatrial nodal cells was measured using standard intracellular microelectrode techniques. Electrophysiological parameters were measured in cells from control animals, and in cells from animals pretreated with reserpine for seven days. These parameters included maximum diastolic potential, the slope of diastolic depolarization, the slope of rapid depolarization, the slope of the plateau, the slope of rapid repolarization and the amplitude of the action potential. The contribution of electrogenic pumping to these parameters was measured by inhibiting the sodium pump with ouabain.

Chronic reserpine pretreatment produced significant decreases in maximum diastolic potential, amplitude and the slopes of rapid depolarization and plateau. The administration of ouabain significantly decreased amplitude and the slopes of rapid depolarization and rapid repolarization. Additionally, the effects of ouabain on amplitude and rapid repolarization were not altered by chronic pretreatment with reserpine. These data indicate that the effects of chronic reserpine treatment are not mimicked by inhibition of the sodium pump with ouabain.

Because atria become specifically supersensitive to the chronotropic effects of catecholamines, sodium pump activity was examined in control and reserpine-pretreated animals before and during exposure of cells to isoproterenol or histamine. Both drugs increased rate primarily by increasing the slope of diastolic depolarization. Administration of isoproterenol and ouabain together in control animals did not produce greater increases in rate than those seen with isoproterenol alone (i.e., acute sodium pump inhibition did not produce supersensitivity).

Different Effects

Chronic reserpine pretreatment enhanced the ability of isoproterenol to increase the slopes of the plateau and rapid repolarization. This effect was not seen in reserpine-pretreated animals stimulated with histamine. This effect also was not seen in cells from control animals stimulated with isoproterenol and ouabain.

It is concluded that this electrophysiological difference could help to explain the catecholamine-specific increase in sensitivity which is produced by chronic pretreatment with reserpine. This electrophysiological difference does not appear to reflect a loss of electrogenic sodium pump activity. (Supported in part by NIH Grant R01-NS-08300, R01 GM-29840 T32 GM-07039).

Carbon Tetrachloride (CCl_4) Toxicity In The Guinea Pig Adrenal Cortex

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ADRENAL necrosis has been described in man and experimental animals after carbon tetrachloride (CCl_4) poisoning. Most of the research on CCl_4 toxicity has been done in liver where lipid peroxidation, the oxidative autocatalytic destruction of unsaturated fatty acids, has been proposed as the mechanism of the toxic effect. Hepatic CCl_4 toxicity is characterized by marked morphological and biochemical alterations, including decreases in the content and activity of enzymes found in the microsomal fraction of the tissue.

Little is known about the mechanism of, or the changes, that accompany CCl_4-induced adrenal necrosis. Studies therefore were carried out to determine the occurrence and extent of CCl_4-induced necrosis in the guinea pig.

CCl_4 Activation

It is well documented that CCl_4 must be metabolically activated in order to exert its toxic effects. In a series of *in vitro* studies, the microsomal fraction of the guinea pig adrenal was shown to active CCl_4, when incubations were carried out in the presence of NADPH (a source of reducing equivalents). Activation of CCl_4 (to the trichloromethyl radical) resulted in decreases in the activity and content of various microsomal enzymes and markedly increased lipid peroxidation. Administration of CCl_4 *in vivo* to guinea pigs, 24 hours prior to sacrifice, resulted in similar changes in adrenal enzymes. However, due to the rapid metabolism of end products used as quantitative estimates of lipid peroxidation, it was not possible to assess the occurrence of this reaction *in vivo*.

Morphologically, CCl_4 administration resulted in the typical pattern of centrolobular necrosis in the liver. In the adrenal cortex, CCl_4 produced a series of necrotic changes including pyknotic nuclei, karyorrhexis, and vacuolated cytoplasm. In the adrenal, these changes were limited to the inner, glucocorticoid-producing zones.

Additional *in vitro* studies were carried out using a chemical inhibitor of lipid peroxidation (EDTA). CCl_4-induced changes in adrenal enzymes were unaffected by the inhibition of lipid peroxidation.

Conclusions

The results indicate the following: (1) the adrenal cortex in the guinea pig is a target site for CCl_4, (2) CCl_4 toxicity causes a decrease in adrenal and hepatic microsomal enzyme activity, (3) CCl_4 toxicity in the adrenal is more prominent in the inner zones of the cortex, morphologically, and (4) lipid peroxidation is not obligatory for CCl_4 to exert its toxic actions on the adrenal.

Medical Grand Rounds

From the West Virginia University Medical Center

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Drug Use In The Elderly

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Elderly patients are at increased risk for adverse reactions to medication. Safety data and dosage recommendations are generally derived from experience with young, healthy volunteers. Both physiologic changes and associated diseases render this information less relevant to the elderly. Multiple-drug regimens are common, and tend to increase risk. Stereotypes of the elderly are presented in some drug advertising, and may encourage inappropriate prescribing. New drugs represent a particular danger to the elderly.

A therapeutic goal in the elderly should be the lowest doses of the fewest drugs.

OLDER Americans take many medications. Although they constitute only 12 per cent of the population, they fill 25 per cent of all prescriptions. In 1980, the average 65-year-old who came to see a physician was taking five drugs. For a variety of reasons the elderly are more likely to suffer adverse reactions to drugs. Some of these reasons are reviewed below.

Testing of new drugs for safety and efficacy generally is done with young, healthy volunteers. Experimenting on the frail elderly is considered to be unethical. As a result, however, when a new drug is marketed in the United States, the number of elderly who receive it may be hundreds of times greater than the total number who have tested it prior to marketing. And this will occur over a short period of time. The experience with Selacryn® (ticrynafen) and Oraflex® (benoxaprofen) shows that lethal side effects can become apparent shortly after marketing.

Coles *et al.*[1] considered five new nonsteroidal anti-inflammatory drugs (NSAIDs) and compared side effects during drug-company testing with the accumulated experience in two large arthritis centers. They demonstrated "a tendency for severe side effects to occur more frequently in community use than would be predicted from clinical trials."

The change from wage earner to pensioner can be difficult, and some elderly spend an average of 20 per cent of their disposable income on medication.

Thus a situation has developed in which the most vulnerable group of adults is taking the largest number of medicines and having the greatest number of adverse reactions at a time when they are least able to pay for the medications.

Physiologic Changes

Absorption. Gastric acidity, small bowel absorptive surface area, motility, and blood flow are all reduced in the elderly. In the few drugs that have been studied, absorption has not been altered, and expected blood levels have been achieved.

Distribution. Total body water, lean body mass and bone density are reduced with aging.

There is a marked increase in percentage of body fat. Serum albumen decreases with increasing age. These changes alter the volume of distribution of many drugs. This in turn affects the loading dose and dosage interval.

Metabolism. Renal function deteriorates with age. Glomerular filtration rate (GFR) at age 70 is about 50 per cent that of a 20-year-old. Because of diminished muscle mass, this fall in GFR may not be associated with a rise in serum creatinine. In the elderly a normal creatinine may mask a significant loss of renal function. Nomograms that use age to predict GFR are very rough guidelines because variability among normals tends to increase with age. Hepatic blood flow falls significantly with age, but hepatic capacity for metabolism is so great that this effect is only important for "high clearance" drugs such as lidocaine, amitryptiline and propranolol. Hepatic metabolism of low clearance drugs displays a wide scatter in the aged.

End Organ Responsiveness. Elderly people appear to react adversely to some drugs at blood levels generally considered to be therapeutic. This can result from changes in receptor number or affinity or changes in the end organs themselves. Little research has been done in this area.

In summary, dosage recommendations established in young patients should be used cautiously in the elderly. Unless urgent circumstances exist, low doses should be employed initially and titrated carefully.

Pressures to Prescribe

Drug advertising encourages the prescribing of expensive, ineffective and sometimes dangerous drugs. Valium® (diazepam) is marketed as an adjunctive therapy for ulcers, hypertension and angina. There is no evidence of efficacy in any of these conditions. A combination (Limbitrol®) of Librium® (chlordiazepoxide) and amitryptiline is recommended for headache, and of Librium® and clidinium for stomach pain (Librax®).

Expensive antibiotics with few if any indications in clinical practice are marketed aggressively. Dalmane® (fluorazepam) is the most widely prescribed hypnotic in the United States, yet there is no convincing evidence of its superiority over other benzodiazepine hypnotics. It is a triumph of marketing and may in fact be more dangerous than some of the shorter-acting agents (see below).

The elderly are endangered by this advertising for two particular reasons. The first is stereotyping. Women commonly have been portrayed in drug advertising as frivolous, depressed, complaining psychoneurotics. All-purpose minor tranquilizers, stimulants, antidepressants and phenothiazines have been touted.

An increasing emphasis on unkempt, hostile, anxious, disruptive, elderly patients is developing in current advertising. This stereotyping may encourage stereotype prescribing with less than complete medical evaluation, and it tends to demean both women and the elderly.

A second source of risk to the elderly is the enthusiastic promotion of new drugs, for example, Zantac® (ranitidine), Lozol® (indapamide), Wytensin® (guanabenz) and Bumex® (bumetanide). The toxicities of these drugs are not yet known. With aggressive advertising, $6 million of Oraflex® was sold in its first month. Eleven deaths resulted and the product was withdrawn from the market. When they are released, new drugs have been tested little or not at all in elderly patients. In considering new drugs, claims for safety and lack of side effects should be ignored until some experience is generated with older patients.

Specific Situations

Digoxin:

Several recent studies have shown good evidence that maintenance digoxin can be discontinued in patients with chronic compensated congestive heart failure (CHF) and normal sinus rhythm[2]. In one study of 24 patients "with coronary artery disease with documented CHF, most of whom were receiving diuretics or vasodilators, or both, digoxin withdrawal had no adverse clinical or hemodynamic effects."[3] A double-blind crossover study of 30 consecutive outpatients indicated "that long-term digoxin therapy has only minor effect on cardiac performance that is without apparent clinical importance in a representative population of ambulatory outpatients."[4] These studies specifically excluded all patients in whom digoxin was used to treat or prevent atrial fibrillation or other atrial tachyarrhythmias.

Digoxin toxicity is a frequent, serious and potentially lethal complication of prolonged digoxin therapy. A carefully-monitored trial of drug withdrawal is probably indicated in many selected elderly patients.

Phenothiazines:

As mentioned above, pharmaceutical manufacturers tend to promote the use of major tranquilizers for relatively minor indications. The risk of developing tardive dyskinesia rises

steadily with age;[5] this syndrome is crippling and generally irreversible. Antipsychotics should be reserved for bizarre behavior, psychosis and agitation. They should be used after all other causes of behavior and thought disorders have been eliminated.

Sleeping pills:

Complaints about sleep and sleep disorders occur with increasing frequency in the elderly. Sedative hypnotics are prescribed in great numbers, although the Institute of Medicine of the National Academy of Sciences, after reviewing 150 efficacy studies, found that no benefit from the use of sleeping pills has ever been documented satisfactorily. They defined "benefit" as reduced somnolence or improved performance the following day. More total sleep time and fewer patient complaints were not considered to define efficacy.

A "White Paper" on sleep and aging prepared by the National Institute on Aging singled out Dalmane® for its ability to exacerbate sleep apnea, a condition which was found to be highly prevalent among the asymptomatic elderly. The Paper emphasizes "the complete lack of objective knowledge about the efficacy and safety of sleeping pills in the elderly."[7] Despite this, in 1978, 25 million prescriptions were written for sleeping pills.

Antihypertensives:

Hydrochlorothiazide is a commonly used step-one drug. Although the Physician's Desk Reference (PDR) recommends initial doses from 50 to 100 mg., non-industry sources[8,9] advocate beginning with 25 mg. They and others[10] note increasing side effects, especially hypokalemia at increasing dosages, with little increase in therapeutic benefit. Low doses are particularly important in the elderly who are more vulnerable to severe electrolyte disturbances.

Nearly all antihypertensives can cause sexual dysfunction. Despite widespread prejudice, many older people enjoy important satisfaction from sex. An open, nonjudgmental inquiry by the physician at the follow-up visit may help uncover such problems and reduce serious morbidity. The query might be started by saying "This medication gives many people sexual problems . . ."

Anti-inflammatory Drugs:

It has not been too long since the toxicity of acute reversible renal insufficiency from prostaglandin inhibitors was discovered. Advanced age is an important risk factor. In one small series the mean age of cases was 76 years.[11] Non-steroidals cause frequent central nervous system side effects including dizziness, confusion, depression and paranoid symptoms among the elderly. Low initial doses of these drugs are rational, especially when used in treating chronic complaints.

Allopurinol:

Asymptomatic hyperuricemia does not increase the risk of subsequent renal insufficiency.[12,13] It is associated with a very small increase in the risk of kidney stones, but there is no evidence that treating asymptomatic hyperuricemia will restore this risk to normal. Allopurinol should be used in recurrent gout or urate nephrolithiasis that is difficult to control with conservative measures. Its use in cancer chemotherapy is well established. Hypersensitivity reactions are the most common adverse reactions, and they may occur after months or years of chronic drug use.

Cerebral vasodilators:

Senile dementia of the Alzheimer's type (SDAT) and multi-infarct dementia account for a large majority of dementias in the elderly. Despite wide usage, cerebral vasodilators have never been shown to produce important clinical improvement. For example, in 1973, the American Medical Association found papaverine and ethaverine compounds "to be lacking evidence of clinical efficacy." The National Academy of Sciences stated that "substantial research is required" to demonstrate any beneficial effects. In 1981, sales of papaverine and ethaverine exceeded $45 million.

No drug has been shown to improve functional status or to diminish hostile behavior in patients with SDAT.[14] Usual doses of ergoloid mesylate (Hydergine®) produce small benefits on some psychometric tests. Research with high doses has shown improvement in self-care ability in a small number of patients. This remains experimental at present. As with all cerebral vasodilators, Hydergine® is expensive.

Cimetidine:

Cimetidine frequently causes confusion in the elderly, probably due to its anticholinergic activity. Because it is excreted by the kidneys, it should be given at reduced doses to the elderly. Sucralfate may be indicated in radiographically documented ulcer disease. The safety of ranitidine (Zantac®) is as yet undetermined.

Muscle Relaxants:

Cyclobenzaprine (Flexeril®) is related to the tricyclic antidepressants and shares a similar

cardiac toxicity. A two-week crossover study in neck and low back pain showed minimal benefit over placebo.[15] Efficacy studies of all these drugs is similarly ambiguous. Sedation is probably an important effect. The cost and toxicity of these drugs is considerable.

Summary

Many elderly Americans are taking excessive numbers of prescription drugs. Over-the-counter medications are a comparable problem. A few moments of education can sometimes blunt the enthusiasm some patients have for receiving prescriptions. Nonpharmacologic measures are often effective. Mild exercise, a hot shower, warm milk and a dull book can provide marked sedation. A few days of bed rest is adequate therapy for many cases of low back pain.

New drugs are perilous, particularly in old people. Despite great industry pressure, new drugs should be reserved for situations in which more thoroughly tested drugs have proved ineffective or where some other valid reason exists to expose patients to an unmeasured risk. Otherwise, standard therapy should be used.

All drug information in the PDR is there because the drug companies have paid the publishers to include it. Drug companies spend more than $5,000 per physician per year to encourage physicians to prescribe their drugs. More reliable prescribing information can be obtained from the Medical Letter, the AMA Drug Evaluations or textbooks such as Goodman and Gilman.

Studies of drug compliance show that simple daily regimens are more likely to produce compliance. Schedules of multiple daily doses may be unrealistic in elderly patients. Frequent review of medication lists can prevent continued ingestion of unnecessary medications. Low initial doses and careful subsequent titration will minimize both cost and toxicity.

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The President

THE MYTH OF MEDICARE

THIS morning I read in the *AMA Newsletter* that Ways and Means Committee Chairman Dan Rostenkowski (D-IL) was expected to offer an amendment on the House floor that would enforce mandatory assignment, and also would roll back and freeze for six months Medicare payments to physicians for services to hospital patients. This amendment would enforce mandatory assignment and the payment freeze by requiring hospitals to condition physician admitting privileges on 100-per cent acceptance of assignment, and by assessing criminal penalties against physicians for failure to comply. *Certainly, the language of this amendment serves to incriminate physicians for the near insolvency of the Medicare fund.*

Let us examine briefly the facts concerning the Medicare funds. For fiscal year 1982, 67 per cent of the total budget was utilized for inpatient hospital services. Only 24 per cent of the budget went to physicians and other suppliers. Furthermore, approximately 10 per cent of the total budget was utilized for the treatment of chronic kidney disease. What is the point of this analysis? It is apparent that limiting one's analysis to the cost of the Medicare Program misses the major issue.

The major problem that the Medicare Fund is experiencing is not increased costs—increased costs are merely a reflection of the rapidly increasing demand for medical services since 1965. With the passage of the Medicare Amendment in 1965, the American people were promised the best of health care, and that accessibility to that care should be unlimited. The medical profession has done its job very well. Existing medical schools were expanded, and new schools were started. We are now producing about 17,000 physicians per year, and the supply of physicians will soon exceed the demand for these services.

The improvement in technology has been miraculous, and these improvements have added significantly to the quality of life. People are living longer, and once dreaded diseases are now being cured. Yes, American Medicine has responded to the challenge—we have improved the accessibility to care, and there is a single health care standard for all people of this country. On an annual basis, Medicare has grown from a $3.3 billion program in fiscal 1967 to a $50 billion program in fiscal 1982.

The crux of the problem is that the Federal Government has made promises to the citizens that it is now unwilling to honor, and the government is refusing to pay its fair share of the medical costs. It plans to shift those costs to the private sector. With DRGs and other cost-control measures, it is apparent that the accessibility of care will be reduced.

So, Chairman Rostenkowski, why not tell the American people that the near insolvency of the Medicare fund is not a result of physician fees, but the direct result of the government's refusal to pay its fair share of the medical costs for which the government stimulated the demand by the passage of the Medicare Amendment?

Carl R. Adkins

CARL R. ADKINS, M. D., *President*
West Virginia State Medical Association

The West Virginia Medical Journal

Editorials

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author shall be held entirely responsible. Editorials printed in The Journal do not necessarily reflect the official position of the West Virginia State Medical Association.

UNIQUE ASSIGNMENT

The announcement of Dr. David Z. Morgan's new role with the West Virginia University School of Medicine (described under WVU Medical Center News in this issue of *The Journal*) should be received with enthusiasm by West Virginia physicians, many of whom had expert guidance from "DZ" through their years of undergraduate medical education. In a new activity probably unique in the educational efforts of a medical school, he has undertaken an assignment perhaps best described as "outreach clinical consultant."

Effective November 1, Doctor Morgan became available on the request of physicians in a community to spend time working alongside individual physicians, consulting on care of patients and discussing problems of medical care.

As outreach clinical consultant, Doctor Morgan will bring continuing medical education to the doctor's practice, to the "teachable moment," the physician/patient interview. As back-up support for his interaction with community physicians, he will have the competence of faculty in all specialties and the learning resources of the School of Medicine library.

For the time they spend in consultation and patient care discussions with Doctor Morgan, physicians will receive hour-for-hour Category 1 CME credit through the WVU Office of Continuing Medical Education.

As a result of Doctor Morgan's experiences, the Office of Continuing Medical Education hopes to gain insight as to the kinds of continuing education topics that will be most appealing and valuable to the practicing physician. This should be especially helpful considering the growing interest in making continuing medical education more meaningful for the physician by making it more related to the physician's practice.

The effectiveness of such "practice-linked" continuing medical education is suggested as the "Next Step" in a very thoughtful *Special Communication* from Phil R. Manning, M. D., in the February 25, 1983, issue of the *Journal of the American Medical Association.* Doctor Morgan's CME efforts on behalf of the physicians with whom he consults should help to further this concept.

In his contacts with physicians, not only will he be an ambassador for the School of Medicine, but as Vice President of the West Virginia State Medical Association, Doctor Morgan will have opportunity to assess and evaluate physicians' expectations of the Association and its programs.

The physicians of West Virginia are fortunate that the School of Medicine's interest in their continuing medical education makes available to them an internist with the excellent reputation of Doctor Morgan. We can expect the same gentle guidance and quality of thought and effort in his new position as he always demonstrated in his 17-year stint as administrator of Student Affairs at the WVU School of Medicine.

OTHER FORCES

Considerable media attention has been directed recently to the first decline in 17 years in first-year enrollment in the nation's 127 medical schools. Actually, the drop was small —only 90 from 17,320 in 1981-82 to 17,230 in 1982-83—among a total of 66,866 students enrolled in all classes. The total medical school enrollment reflected a slight increase, of less than one per cent, over 1981-82.

There might be some significance in both the first-year and total enrollment trends. The number of medical school graduates also was off somewhat, from 15,985 in 1981-82 to 15,728 in 1982-83, but four medical schools changed from a three to a four-year program.

Perhaps the more important data reported in the *Journal of the American Medical Association* annual report on medical education in the nation lies, however, in a summary of application

activity for medical schools over the last 20 years.

Specifically, the 35,730 who applied to medical schools for admission in 1982-83 were off about 1,000, or 2.7 per cent, from the previous year. It is true that the application figure has gone up and down for several years, reflecting some variation in reporting by various schools, some change in the number of medical schools and other factors.

But the 36,727 application figure for 1981-82 was the highest since 1977-78. Why the big change in 1982-83? Are well-informed young people influenced by various studies predicting a physician surplus in coming years? Or are other forces at work?

We suspect the "other forces" component is a major one, although admittedly there is no valid evidence to support that view. Again, however, those who might consider professional careers in Medicine generally are bright and aware of the world around them. And they have to be at least somewhat aware of the non-medical distractions physicians now have to endure in trying to provide quality medical care.

We're referring here to what might be summed up as "regulitis;" and a downright anti-Medicine, anti-professional climate reflected in a variety of legislative, media and other circles.

When the chairman of the U.S. Senate's Finance Committee says that last year was the year of the hospitals, and this is the year of the physicians, reasonable individuals — including those needing as well as providing medical care —have plenty of cause to wonder.

This is the same Senator who thinks the way to pay for a health insurance program for the jobless is to freeze Medicare payments to physicians. There's nothing to indicate any thought or concern as to what negative impact such an approach might have on the base-line issue of continued available, high-quality care for the elderly.

Almost anywhere a physician cares to look, he can expect to find a bureaucracy holding out its left hand for a subsidy, while ready to hand medical and other providers a regulatory clubbing with the right.

Some of these thoughts and concerns have been around now for quite a while. But it still was somewhat of a shock to hear a practicing physician recently tell a group of business leaders that he would not now recommend Medicine as a career to his own children.

Too many physicians down the road? Maybe, for a while. And we certainly can anticipate further giant strides in technology and the like. But the seas are not altogether calm, and are not likely to be.

COMMUNICATIONS

Much has been made — and properly so — of the critical role physician-patient rapport plays in effective medical care. But what about a communications gap among physicians and others on the health care team?

Professor Ralph Aloisi, who heads the Department of Biology and Health Sciences at the University of Hartford in Connecticut, sees real problems with what he calls "terrible biases" prevailing within a medical support group ultimately responsible for patient well-being.

The end result, Professor Aloisi feels, is that the patient suffers. "All of these people have been educated," he observed, "but they haven't been educated *together* and they're not accustomed to communicating effectively." In addition, health care professionals often "don't know how to deal with death and don't know how to talk to patients."

One solution to the problem, according to the educator, is to relate more closely medical training to a liberal arts environment. "The scientific part of one's education can become quickly outdated," he has said. "In fact, the science of immunology is changing so rapidly that anything you learn today will likely be obsolete in two years."

In contrast, "learning in the liberal arts — subjects like philosophy, ethics and communication — is timeless. And not only will these subjects give health care workers the background to better deal with people, they will also allow them the option, at a later point, of making a career change — into, say, hospital administration," Professor Aloisi notes.

He also is convinced that when medical training takes place in a work environment like a hospital, rather than a learning environment like a university, prejudice between health care professionals is intensified.

At the University of Hartford, Professor Aloisi heads up programs in medical technology and health science as well as respiratory therapy. The respiratory therapy program is a cooperative effort with Hartford Hospital, which provides facilities for the clinical aspect of the training.

GENERAL NEWS

'Disability Trap' Panelists, Speaker Announced

John J. Banks, C.R.C.

Judith G. Greenwood, Ph.D.

Members of a panel to discuss "Into and Out of the Disability Trap" during the 17th Mid-Winter Clinical Conference have been announced by the Program Committee.

The panel discussion concerning the physician and the procedures and pitfalls in disability determination will constitute the Saturday afternoon, January 28, session of the annual continuing medical education gathering to be held January 27-29 in Charleston at the Marriott Hotel.

Sponsors are the State Medical Association and the Marshall University and West Virginia University Schools of Medicine.

The conference will follow by only a few months the opening of the new Charleston Town Center, which is located directly across from the meeting site. The Program Committee is expecting the multi-million-dollar shopping center to attract, for the 1984 conference, a larger number of participants and spouses than usual.

'Defining the Problem'

Providing background information in an introductory presentation, "Defining the Problem," prior to the Saturday afternoon panel discussion will be Judith G. Greenwood, Ph.D., the Program Committee also announced. Doctor Greenwood is Director of Research and Development, West Virginia Workers' Compensation Fund.

Members of the panel will be: John J. Banks, C.R.C., Executive Director, National Rehabilitation Counseling Association, Alexandria, Virginia; Robert A. Keisman, M. D., Medical Advisor, Disability Programs Branch, Region III, U. S. Department of Health and Human Services, Philadelphia; Gretchen O. Lewis, Commissioner, West Virginia Workers' Compensation Fund, Charleston;

John L. McClaugherty, LL.B., partner in the law firm of Jackson, Kelly, Holt and O'Farrell in Charleston; and S. F. Raymond Smith, J.D., Director, Benefits Services, United Mine Workers, District 29, Beckley. (See accompanying story for additional biographical information concerning Doctor Greenwood and the panelists.)

Doctor Ghiz Moderator

Moderating the Saturday afternoon session will be Robert L. Ghiz, M. D., Charleston orthopedic surgeon and Clinical Associate Professor of Orthopedic Surgery, WVU School of Medicine.

"We believed disability determination problems reported in the state justify an entire afternoon for discussion. This also should provide plenty of time for questions from the audience, the major reason for setting up the panel," said Joseph T. Skaggs, M. D., of Charleston, Chairman of the Program Committee.

The conference, featuring some 18 physician and other speakers, will begin at 2 P. M. on Friday and end at noon on Sunday. Other sessions are scheduled Friday afternoon, Saturday

Robert A. Keisman, M. D.

Gretchen O. Lewis, B. S.

John L. McClaugherty, LL.B.

S. F. Raymond Smith, J.D.

morning and Sunday morning. As usual, special concurrent sessions for physicians and the public are scheduled Friday evening.

"West Virginia Board of Medicine Update," an informative presentation on the activities and problems of that Board, is planned for the Friday evening physicians' session; and "Rape and Incest: The Hidden Crisis," will be the title for the concurrent public session.

Speakers for the public session will be Diane W. Mufson, M.A., psychologist at the Cammack Center, Inc. for young people in Huntington, and William E. Walker, M. D., emergency department physician at St. Mary's Hospital in that city, and Associate Professor of Surgery at MU School of Medicine.

Exhibits, 'Meet the Faculty'

Also on the conference agenda are some 15 scientific and other exhibits to be on display throughout the meeting, and 5 o'clock "Meet the Faculty" cash bars following the afternoon sessions on Friday and Saturday.

The following additional conference speakers and topics, as announced previously, will be on the program:

Friday Afternoon: "AIDS"—James N. Frame, M. D., third-year resident, internal medicine, Charleston Area Medical Center/WVU Medical Center, Charleston Division; "Children of Divorce: Problems and Solutions" — Arthur E. Kelley, M. D., Associate Professor of Psychiatry and Child Psychiatry, Department of Behavioral Medicine and Psychiatry, WVU, Morgantown; and "Flexible Sigmoidoscopy" — Ronald D. Gaskins, M. D., Associate Professor of Medicine and Chief, Gastroenterology Section, WVU, Morgantown;

Saturday Morning: "Parkinsonism and Organic Brain Syndrome"—Albert F. Heck, M. D., Charleston, Clinical Professor of Neurology, WVU: and "Geriatric Pharmacology" — Mary Beth Gross, Pharm. D., Assistant Professor of Clinical Pharmacy, WVU Charleston Division;

Sunday Morning: "Intracoronary Thrombolysis: Clinical Experiences to Date"—Joseph F. Hanna, M. D., Assistant Professor of Medicine and Director of Invasive Cardiology, MU and Veterans Administration Medical Center, Huntington.

Additional speakers for Saturday morning and Sunday morning on epilepsy, arthritis and disc disease will be announced in the January issue of *The Journal.*

The program meets the criteria for 14 hours of credit in Category 1 of the Physician's Recognition Award of the American Medical Association, and also is approved for 14 Prescribed hours by the American Academy of Family Physicians.

Fees, Registration

A registration fee of $50 will be charged all registrants except nurses, medical students, interns and residents. For advance registration, make checks payable to West Virginia State Medical Association, and mail to the Association at P. O. Box 1031, Charleston 25324.

The Charleston Marriott is holding a block of rooms for conference attendees, and reservations should be made by January 6. Those who register for the conference in advance will receive from the Association a postage-paid Marriott reservation request card specifically designated for the conference. Persons making reservations directly with the hotel—in order to receive group rates—should specify that they will be attending the Mid-Winter Clinical Conference. Group rates are $52 for a single room and $60 for a double.

Program Committee

Members of the Program Committee, in addition to Doctor Skaggs, are Drs. William O. McMillan, Jr., and C. Carl Tully, both of Charleston; Richard G. Starr, Beckley; Maurice A. Mufson, Huntington, and Robert L. Smith, Morgantown.

The Program Committee is receiving continuing assistance from WVU Charleston Division staff member J. Zeb. Wright, Ph.D., Coordinator of Continuing Education, Department of Community Medicine; and Sharon A. Hall, Conference Coordinator.

Remaining speakers and program details will be presented in the January issue of *The Journal.*

Disability Panel Participants Reflect Wide Experience

Additional biographical information concerning the introductory speaker and panelists for the Saturday afternoon, January 28, session of the Mid-Winter Clinical Conference on "Into and Out of the Disability Trap" (see accompanying story) is presented below.

"It will be highly unusual to have in Charleston this number of experts representing such a broad range of experience in rehabilitation and disability determination. This should give our doctors an excellent opportunity to get answers to their questions," said Dr. Joseph T. Skaggs of Charleston, Chairman of the Program Committee.

Judith G. Greenwood, Ph.D. (introductory speaker), served as technical consultant for medical rehabilitation program planning in West Virginia by the State Medical Association's Committee on Vocational Rehabilitation.

Evaluation, Cost Containment

Her duties with the State Workers' Compensation fund include helping to develop standards for disability evaluation and cost containment, and to conduct applied research in disability prevention, treatment, and rehabilitation.

A native of Parkersburg, she holds a B. A. degree from Randolph Macon Woman's College, an M. A. degree from WVU, and M.P.H. and Ph.D. degrees in Social Science and Health Behavior from the University of Oklahoma Health Sciences Center.

John C. Banks, panelist, is a certified rehabilitation counselor (C.R.C.), and serves as chief executive (since 1982) of the oldest professional association for rehabilitation counselors. He is a member of the National Rehabilitation Association's National Commission on Legislation, and is a former NRA board member. He earned a B. S. degree in Industrial Education and Psychology and an M. S. degree in Vocational Rehabilitation and Vocational Evaluation from the University of Wisconsin.

Cardiologist

Robert A. Keisman, M. D., panelist, also is in the private practice of cardiology in Philadelphia. He received his M. D. degree in 1950 from the University of Pennsylvania, and completed postgraduate work there and at Cornell University. His research has been in electrocardiography and angiography.

Gretchen O. Lewis was appointed Commissioner of the State Workers' Compensation Fund in April, 1980, after serving as Director of Budget Planning for the West Virginia Department of Finance and Administration. A native of North Carolina, she graduated with honors from WVU in 1977, receiving a B. S. degree in Business Administration.

John L. McClaugherty, a native of Princeton, was graduated from Northwestern University, and received his LL.B. degree in 1956 from the WVU College of Law. He is a former Vice President of the West Virginia Bar Association; a Past President of the Kanawha County Bar Association; a member of the Workers' Compensation Committee, National Coal Association; and a member of the boards of Cannelton Industries, Inc., and South Hills Bank, both in Charleston.

He also is President of the Board of Directors of the Charleston Symphony Orchestra, and a Past President of the Kiwanis Club of Charleston.

S. F. Raymond Smith has been with United Mine Workers, District 29, in Beckley since 1981 and in his present position as Director of Benefits Services since March of this year. His office currently is handling several thousand Workers' Compensation claims a year.

He was graduated from Washington and Lee University, and received his law degree in 1980 from WVU.

Review A Book

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication.

Basic and Clinical Endocrinology, edited by Francis S. Greenspan, M. D.; and Peter H. Forsham, M. D. 646 pages. Price $25. Lange Medical Publications, Los Altos, California 94022. 1983.

Current Emergency Diagnosis and Treatment, Edited by John Mills, M. D.; Mary T. Ho, M. D.; and Donald D. Trunkey, M. D. 738 pages. Price $24. Lange Medical Publications, Los Altos, California 94022. 1983.

Handbook of Obstetrics and Gynecology, 8th Edition, by Ralph C. Benson, M. D. 804 pages. Price $13. Lange Medical Publications, Los Altos, California 94022. 1983.

Continuing Education Activities

Here are the continuing medical education activities listed primarily by the Marshall University and West Virginia University Schools of Medicine for part of 1983 and 1984, as compiled by Charles W. Jones, Ph.D., MU Director of Continuing Medical Education; Robert L. Smith, M. D., WVU Assistant Dean for Continuing Education, and J. Zeb Wright, Ph.D., Coordinator, Continuing Education, Department of Community Medicine, WVU Charleston Division. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of The Journal.)

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the WVU Morgantown, Charleston and Wheeling campuses. Further information about CME activities may be obtained from: Office of Continuing Medical Education, MU School of Medicine, Huntington 25701; Division of Continuing Education, WVU Medical Center, 3110 MacCorkle Avenue, S. E., Charleston 25304; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 2000 Eoff Street, Wheeling 26003.

Marshall University

Dec. 10, Sports Medicine Conference: A Program for Primary Care Practitioners

West Virginia University

1984

Jan. 23-27, Snowshoe, 5th Mid-Winter Cardiovascular Symposium (Charleston Division)

Feb. 19-22, Snowshoe, Second Annual Vascular Surgery Conference

March 23, Charleston, Gastrointestinal Problems in the Newborn

Regularly Scheduled Continuing Education Outreach Programs from WVU Medical Center/ Charleston Division

Buckhannon, St. Joseph's Hospital, first-floor cafeteria, 3rd Thursday, 7-9 P. M.—Dec. 15, Jan. 19, Feb. 16 (Vacation)

Cabin Creek, Cabin Creek Medical Center, Dawes, 2nd Wednesday, 8-10 A. M.—Dec. 14, "Common Outpatient Dermatological Problems," Donald E. Farmer, M. D.

Jan. 11, "Management of the Menopausal Patient Including Hormone Therapy," Dimitar Georgiev, M. D.

Feb. 8, "Hyperlipidemia" (speaker to be announced)

Gassaway, Braxton Co. Memorial Hospital, 1st Wednesday, 7-9 P. M.—Dec. 7, "Management of Acute Cardiac Emergencies," G. G. Thakker, M. D.

Jan. 4, "Management of Pulmonary Distress," George L. Zaldivar, M. D.

Feb. 1, "Emergency Care of the Acutely Ill Child," Kathleen Previll, M. D.

Madison, 2nd floor, Lick Creek Social Services Bldg., 2nd Tuesday, 7-9 P. M.—Dec. 13, "Recently Recognized and Sexually Transmitted Diseases," Thomas W. Mou, M. D.

Jan. 10, Feb. 14 (Vacation)

Oak Hill, Oak Hill High School (Oyler Exit, N 19) 4th Tuesday, 7-9 P. M.—Dec. 27, Jan. 24, Feb. 28 (Vacation)

Princeton, Community Hospital Board Room, 4th Thursday, 6:30-8:30 P. M.—Dec. 22, Jan. 26, Feb. 23 (Vacation)

Welch, Stevens Clinic Hospital, 3rd Wednesday, 12 Noon-2 P. M.—Dec. 21, Jan. 18, Feb. 15 (Vacation)

Whitesville, Raleigh-Boone Medical Center, 4th Wednesday, 11 A. M.-1 P. M.—Dec. 28, Jan. 25, Feb. 22 (Vacation)

Williamson, Appalachian Power Auditorium, 1st Thursday, 6:30-8:30 P. M.—Dec. 1, "OB Emergencies," Louis Sanchez-Ramos, M. D.

Jan. 5, Feb. 2 (Vacation)

Former Boxing Champ Manager Sports Medicine Speaker

The former assistant manager of boxing champion Rocky Marciano will be a featured speaker at the Marshall Memorial Sports Medicine Conference on December 10 in Huntington.

"The lunch session will focus on 'The Corner's View of Sports Medicine," said Huntington physician Jose Ricard, who helped organize the MU School of Medicine conference. "Marty

Weill, who worked with Marciano, will speak and show a film of one of the boxer's fights. Ernie Salvatore, sports columnist for the [Huntington] Herald-Dispatch, will discuss the public's view, and Dr. Panos Ignatiadis, a Huntington neurologist, will discuss the medical implications of boxing."

Doctor Ricard said the informally structured conference will consist entirely of workshops. "The afternoon workshops will include 'see and touch' sessions with models so participants can actually practice taping and splinting," he said. "We're urging everyone to wear jeans."

Topics Covered

Topics of special interest will include the use of steroids, the legal aspect of sports injury treatment and the special problems in evaluating athletes' hearts, he said. Other sessions will deal with topics such as heat stress, transportation of injured athletes, injury assessment, resuscitation and nutrition.

The conference runs from 8:30 a.m. to 4:30 p.m., and will be in the Marshall Student Center.

The conference fees will be $65 for physicians, $20 for residents and students, and $30 for others. The registration cost includes lunch and a complimentary pass for both the Friday and Saturday games of the Marshall Memorial Invitational Tournament.

The conference is dedicated to the physicians and their wives who died in the 1970 Marshall plane crash. It is certified for continuing education credit. For more information call Charles W. Jones, Ph.D., at (304) 526-0515.

28 Per Cent Of Americans Notice Doctors' Ads

Physician advertising has been noticed by 28 per cent of Americans, according to a public opinion poll prepared by the American Medical Association of Survey and Opinion Research. Awareness of physician advertising is highest among high income earners (39 per cent) and lowest among those who are 65 years of age and older (17 per cent). The public's awareness of advertising has not increased in the last year. Results for August, 1983, were the same as those for August, 1982.

The percentage of physicians who support advertisement of fees in newspapers or on television or radio has more than doubled since 1978. In that year, eight per cent of physicians respondents supported the concept of listing fees in the media; in this year's poll, 17 per cent supported fee advertising, according to an AMA survey of physician opinions on health care issues. The overwhelming proportion of physicians, however, continue to reject listing fees in the media.

Autopsy Discloses Unusual Kaposi's Sarcoma Case

A unique case of Kaposi's sarcoma in a 31-year-old homosexual man is described in a recent issue of *Archives of Pathology and Laboratory Medicine.*

Upon presentation, the young man had a benign lymphoproliferative condition (characterized by the rapid growth of cells and tissue involved in the immune system) that was treated by steroids, said Lawrence S. Perlow, M.D., of New York's Mount Sinai School of Medicine, and colleagues. The patient then quickly developed Kaposi's sarcoma (KS) and a malignant lymphoreticular process. (Reticuloendothelial cells help in the bodily defense mechanism.)

"The incidence of transformation of angiofollicular hyperplasia to a frankly malignant disease is unknown," the researchers comment. "In our patient, whose initially responsive disease transformed into a fulminant fatal illness, infiltration by malignant lymphoid cells was apparent in the bone marrow, liver, spleen, lymph nodes, kidneys and lungs."

Death Not Classifiable

They added that the cause of the patient's death was "not classifiable according to commonly accepted schemes." While regarded as a case of malignant lymphoproliferative disorder, it actually resembled leukemia more than lymphoma. "Certainly, the usual macroscopic and microscopic features of malignant lymphoma, with grossly recognizable tumor masses and infiltration of organs with architectural effacement, were not present," they said.

The researchers pointed out that Kaposi's sarcoma is well recognized as a part of the acquired immunodeficiency syndrome (AIDS), which usually includes evidence of opportunistic infections and abnormal T-cell configurations. "No infection was documented, even after autopsy, in this patient, and his rapidly fatal illness prevented full measurement of immunologic parameters," they said.

One third of the patients with the usual form of KS have a second cancer. Although diffuse undifferentiated lymphomas, Burkitt's lymphoma, and oral tumors recently have been reported in young male homosexuals, we are not aware of any of these tumors occurring in association with KS," they concluded.

Self-Assessment Computer Courses Available

Computer-generated self-assessment courses that were developed originally for Harvard Medical School now are available for physician-subscribers to AMA/NET, the nationwide telecommunications network of the American Medical Association. AMA/NET's newest feature consists of 20-plus modules or courses in subjects as diverse as abdominal pain and meningitis, coma and cardiopulmonary resuscitation. Using his own terminal, a physician can test his clinical skills through simulated patient encounters that were developed by G. Octo Barnett, M. D., Director of the Laboratory of Computer Science, Massachusetts General Hospital, Boston.

The courses carry continuing medical education credits toward the AMA Physician's Recognition Award.

The computer automatically guides the physician through simulated clinical problems, critiques his problem solving, and suggests alternative approaches he might have used. If the physician disagrees with the computer, he can interrupt the course at any time to send a question or comment to MGH through a built-in electronic mail system. A day later, he can turn on his computer terminal, access his mail, and read a response from an MGH physician.

The charge for connecting to MGH/CME is $25 an hour during prime time (7:00 A.M.-6:00 P.M. Monday through Friday) and $21 an hour at all other times.

A physician who wishes a CME certificate from Harvard must register as a CME user and pay a registration fee of $50 per calendar year.

For further information, contact GTE Telenet Medical Information Network (MINET), 8229 Boone Boulevard, Vienna, Virginia 22180. Telephone (703) 442-2500.

Changing To Chewing Tobacco Not Safer Than Smoking

People who think that chewing tobacco is safer than smoking it are harboring a dangerous notion, said W. Frederick McGuirt, M. D., in the November, 1983, *Archives of Otolaryngology*. His study at the Bowman Gray School of Medicine, Winston-Salem, North Carolina, of 290 patients with oral tumors showed that 57 chewed snuff exclusive of any use of cigarettes, pipes or alcohol. A popular shift from smoked to smokeless tobacco will result merely in a change in the site of tobacco-related cancer, Doctor McGuirt warns.

Medical Meetings

Dec. 3 — Diabetes: Prevention of Complications (Mid-Ohio Valley Continuing Medical Education & Marshall School of Medicine), Parkersburg.

Dec. 3-6 — Am. Society of Hematology, San Francisco.

Dec. 4-7 — Interim Meeting, AMA House, Los Angeles.

Dec. 10—Laser Surgery Seminar (Eye & Ear Clinic of Charleston; Dept. of Surgery, WVU Medical Center, Charleston Division; and Charleston Area Medical Center), Charleston.

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Jan. 19-21—Neurosurgical Society of the Virginias, Williamsburg, VA.

Jan. 27-29—17th Mid-Winter Clinical Conference, Charleston.

Feb. 9-14—Am. Academy of Orthopaedic Surgeons, Atlanta.

Feb. 10-12 — Dermatology & Internal Medicine: Therapeutic Update on Skin Diseases (Medical College of VA), Hot Springs, VA.

Feb. 12-15—W. Va. Perinatal Assoc., Snowshoe.

Feb. 15-19—Am. College of Nuclear Physicians.

Feb. 16-17—AIDS (Drug Development Institute of Am., Colts Neck, NJ), New York City.

March 3-7—Am. Academy of Allergy & Immunology, Chicago.

March 17—Annual Meeting, W. Va. Affiliate, American Diabetes Assoc., Wheeling.

March 25-29—Am. College of Cardiology, Dallas.

March 30-April 1 — Neurological Diseases Seminar (United Hospital Center), Clarksburg.

April 6-8—WV Chapter, AAFP, Charleston.

April 8-14—Am. Academy of Neurology, Boston.

April 9-13—Am. Roentgen Ray Society, Las Vegas.

May 2-5—W. Va. Chapter, Am. College of Surgeons; and W. Va. Otolaryngological Society, White Sulphur Springs.

May 6-9—Am. Urological Assoc., New Orleans.

May 7-9 — Am. Assoc. for Thoracic Surgery, New York City.

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WVU Medical Center
–News–

Compiled from material furnished by the Medical Center News Service, Morgantown, W. Va.

Doctor Morgan Fills New Post As Outreach Consultant

David Z. Morgan, M. D. whose association with WVU and its School of Medicine goes back 35 years, is assuming a new role as a clinical liaison contact to the West Virginia medical community.

Doctor Morgan, 58, left his post as Associate Dean for Student Affairs on November 1 to become the School of Medicine's first "outreach clinical consultant."

David Z. Morgan, M. D.

He is available, on request, to work with individual physicians or hospital staffs for one to several days in their individual communities, consulting with them on patient care problems.

"The result will be a two-way learning experience," School of Medicine Dean Richard A. DeVaul, M. D., said. "Physicians will have learning experiences through Doctor Morgan's consultation and will get hour-for-hour continuing education credit. And through Doctor Morgan, medical school faculty will learn what continuing education topics are needed by practicing physicians."

Association Tie-In

Doctor Morgan also is Vice President of the West Virginia State Medical Association, and is scheduled to become President in August, 1985. Doctor DeVaul said the new assignment will give Doctor Morgan an opportunity to assess and evaluate what members expect from the Association and its programs.

The Dean commented that Doctor Morgan has provided "outstanding service to the School of Medicine and the state of West Virginia as a faculty member and Associate Dean."

"I asked him to assist me in the critically needed area of strengthening relationships with the medical community of the state, many of whose members he knows intimately from their years at the School of Medicine," he said.

"He will be providing direct service to physicians as a consultant, promoting our continuing education programs, making our referral service better known, and encouraging support for the School of Medicine."

Dean DeVaul said John F. Foss, M. D., Associate Professor of Obstetrics and Gynecology, will succeed Doctor Morgan as Associate Dean for Student Affairs.

Doctor Morgan, a direct descendant of West Virginia's first settler, Morgan Morgan, was born in Fairmont, attended Kingwood High School and was graduated from WVU in 1948. He attended the then two-year WVU School of Medicine and completed his medical training at the Medical College of Virginia in 1952.

Special Interest Cardiology

He interned at Ohio Valley General Hospital in Wheeling and practiced in Morgantown before completing a residency in internal medicine at WVU Hospital in 1963. His specialty interest is cardiology.

He joined the medical faculty in 1963, became Assistant Dean three years later and Associate Dean in 1972.

Doctor Morgan is a former President of the Monongalia County Medical Society and has maintained an active practice as a member of the WVU Department of Medicine faculty.

He is a Navy veteran and a member of many state and national professional groups including the American College of Physicians. He is a former Chairman of the West Virginia Joint Council on Teaching Hospitals, and in 1976-77 served as chairman of a popularly elected commission which overhauled the Morgantown city charter.

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Obituaries

MARSHALL GLENN, M. D.

Dr. Marshall (Little Sleepy) Glenn of Charles Town died on October 13 in a Washington County (Maryland) hospital as a result of injuries from a car accident that day in Charles Town. He was 75.

Doctor Glenn, a surgeon, was still in practice at the time of his death, and was a member of the staff of Jefferson Memorial Hospital in Ranson.

A native of Elkins, Doctor Glenn's early prominence was on the West Virginia sports scene, beginning at Elkins High School, where he was an all-around athlete and all-state basketball player from 1924 through 1926.

He attended West Virginia University, where he excelled in both football and basketball from 1927 through 1930. He and his brother, the late Albert (Big Sleepy) Glenn, were among the first 20 athletes inducted into the state sportswriters Hall of Fame.

Following graduation from WVU, Doctor Glenn assumed head coaching duties at Martinsburg High School, remaining there until 1934, when he returned to the University and became head basketball coach. In 1937, he became head football coach. His 1937 football team finished 8-1-1 and defeated Texas Tech 7-6 in the Sun Bowl.

Doctor Glenn received his B.S. degree from WVU in 1930, and his two-year degree in medicine from WVU in 1935. He earned his M. D. degree in 1938 from Rush Medical School in Chicago, and interned at Harper Hospital in Detroit.

During World War II, Doctor Glenn served as flight surgeon for the Navy's "Bye Bye Blackbird" flying unit in the South Pacific.

He was the owner-operator of the Sleepy Hollow Golf Course, which he established on his farm just north of Charles Town, where he resided.

Doctor Glenn was a member of the Jefferson County Medical Society and the West Virginia State Medical Association.

Survivors include the widow; two daughters, Mary Ann Hammann of Shepherdstown and Georgette Glenn, at home; three sons, Walter M. Glenn of Franklin, Tennessee; Marshall Glenn II of Charles Town, and James S. Glenn, at home; a sister, Margaret Hill of Dayton, Virginia, and a brother, Joseph C. Glenn of Philadelphia, Pennsylvania.

* * *

EDWARD V. HENSON, M. D.

Dr. Edward V. Henson of Wilmington, Ohio, formerly of South Charleston, died on November 1 in a Wilmington hospital. He was 66.

Doctor Henson, born in Nanticoke, Pennsylvania, was a former Plant Physician and Medical Director for Union Carbide Corporation in South Charleston.

A veteran of World War II, Doctor Henson moved from South Charleston to Chicago in 1961. He received his M. D. degree in 1943 from Jefferson Medieal College, interned at that institution's hospital, and completed his residency at St. Francis Hospital in Charleston.

Doctor Henson was a former member of the State Medical Association.

Survivors include the widow; two sons, Robert J. Henson and Paul E. Henson, both of Wilmington; a brother, Robert J. Henson of Philadelphia, and a sister, Mrs. Ruth Fox, also of Philadelphia.

* * *

GLEN JOHNSON, M. D.

Dr. Glen Johnson a general practitioner in Wayne since 1924, died on October 11. He was 93.

The University of Tennessee honored him at its 1963 commencement for his service to the community and as Norfolk and Western Railway Company surgeon.

Born in Paintsville, Kentucky, he also practiced in Dunlow and East Lynn before going to Wayne.

Doctor Johnson received his medical education at the former Lincoln Memorial University Medical Department in Knoxville, Tennessee.

Survivors include the widow and two daughters, Mrs. Wallace Rutherford of Huntington and Mrs. Ted Cyrus of Columbus, Ohio.

* * *

JAMES W. PECK, M. D.

Dr. James W. Peck, Summersville general practitioner, died on October 9 in a Richmond, Virginia, hospital. He was 60.

A native of Summersville, Doctor Peck had practiced there since 1948.

He was graduated from Duke University, and received his M. D. degree in 1947 from the Medical College of Virginia. He interned at Ohio Valley General Hospital in Wheeling.

Doctor Peck was a member of the Central West Virginia Medical Society, West Virginia State Medical Association and American Medical Association.

He served with the Navy during World War II and the Army in the Korean Conflict.

Survivors include the widow; three sons, James W. Peck, Jr., of Richmond, Virginia, and Robert A. Peck and John D. Peck, both of Summersville, and a daughter, Mrs. Patricia Ann Landers of Summersville.

* * *

ROBERT J. SNIDER, M. D.

Dr. Robert J. Snider of Wheeling died on October 18 in a hospital there. He was 90.

Born in Tiffin, Ohio, Doctor Snider practiced internal medicine in Wheeling for 50 years, and was a member of the staff of Wheeling Hospital.

He received both his undergraduate and M. D. (1916) degrees from the University of Michigan, interned at the University's hospital, and completed postgraduate work at Harvard Medical School.

Doctor Snider served with the U. S. Army Medical Corps, attached to the British Army during World War I. While serving, he was severely wounded, receiving the U. S. Purple Star and the British Distinguished Service Order, the Army's second highest decoration for valor.

He was an honorary member of the Ohio County Medical Society, West Virginia State Medical Association and American Medical Association.

Surviving are four sons, Robert J. Snider III and William H. Snider, both of Wheeling; John F. Snider of Clarksburg, and Paul W. Snider of Indiana, Pennsylvania.

* * *

LEE B. TODD, M. D.

Dr. Lee B. Todd of Quinwood (Greenbrier County), died on November 2 in a Low Moor, Virginia, hospital. He was 78.

Doctor Todd was a general practitioner in Quinwood from 1934 to 1943 and again from 1951 until his death. He also was a former Health Department Director in Newport News, Virginia, his birthplace.

Doctor Todd was graduated from William and Mary College, and received his M. D. degree in 1932 from the Medical College of Virginia, where he also interned and took his residency.

A veteran of World War II, he was an honorary member of the Greenbrier Valley Medical Society, West Virginia State Medical Association and American Medical Association, a member of the Association of American Physicians and Surgeons, American Academy of Pediatricians, and American Heart Association, and a Fellow of the Royal Society of Health.

Survivors include the widow; two daughters, Mrs. Jane Young of Newport News and Mrs. Ann Jones of Copper Hill, Virginia; a son, John R. Todd of Wytheville, Virginia, and a sister, Mrs. Elizabeth Topping of Newport News.

* * *

ROBERT S. WHITE, M. D.

Dr. Robert S. White of Paris, Tennessee, formerly of Clarksburg, died on September 13 at his home. He was 87.

Before retirement in 1962, Doctor White, a former member of the State Medical Association, practiced in West Union and at the Veterans Administration Hospital in Clarksburg.

He was born in Camden (Lewis County), and received his M. D. degree in 1942 from the University of Tennessee.

Surviving are the widow and one sister, Mrs. Omer L. Paquette of Malverne, New York.

* * *

JOHN W. YOST, JR., M. D.

Dr. John W. Yost of Bluewell (Mercer County), a general practitioner, died on October 12 in a Bluefield hospital. He was 72.

Born in Gilliam (McDowell County), Doctor Yost had practiced in Bluewell for 25 years. He had been located previously in Wheelwright, Kentucky, and in Holden, Princeton and Williamson.

He received both his undergraduate and M. D. (1936) degrees from the University of Virginia, interning at the University's hospital.

Doctor Yost was a member of the Mercer County Medical Society and West Virginia State Medical Association.

Survivors include three brothers, C. Keith Yost and Morris M. Yost, both of Bluefield, and Ralph F. Yost of Williamson.

Mrs. Hogshead, Past President Of State Auxiliary, Dies

Mrs. Norma Hogshead of Nitro, President of the Auxiliary to the State Medical Association in 1942-43, died on October 30 at the home of a son, Dr. George W. Hogshead, with whom she resided. She was 91.

Mrs. Hogshead, formerly of Montgomery, was editor of the book, *Past Presidents of the West Virginia State Medical Association, 1867-1942*, and editor of *Past Presidents of the Woman's Auxiliary to the West Virginia State Medical Association, 1925-1950.*

A native of Adams County, Iowa, she was a former employee of the West Virginia Water Company in Montgomery with 30 years' service.

Mrs. Hogshead was a Past President and honorary life member of the Auxiliary to the

Fayette County Medical Society. She also was a member of Montgomery Presbyterian Church, Montgomery Women's Club, Daughters of the American Colonists, and Daughters of the American Revolution.

Mrs. Hogshead was an ardent supporter of the Education and Research Foundation of the American Medical Association (AMA-ERF).

Other survivors include a son, Dr. Ralph Hogshead, Jr., of Morganton, North Carolina; a daughter, Dr. Ida May Steele of Nitro, and a brother, Homer C. Snodgrass of Corning, Iowa.

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County Societies

CABELL

Dr. Stebbins B. Chandor was the speaker for the meeting of the Cabell County Medical Society on October 13 at the Holiday Inn-Gateway in Barboursville.

Doctor Chandor, Chairman of the Department of Pathology at Marshall University School of Medicine, gave an interesting talk describing HRA immune hyperacute, acute and chronic transplant rejection action.

The Society observed a moment of silence in the memory of the late Dr. Charles P. S. Ford of Huntington. — S. Kenneth Wolfe, M. D., Secretary.

* * *

FAYETTE

The Fayette County Medical Society met on October 5 at Montgomery General Hospital.

The guest speaker was Dr. Tom Madhavan of Beecham Laboratories, whose topic was "Pneumonias." — Serafino S. Maducdoc, Jr., M. D., Secretary-Treasurer.

* * *

McDOWELL

Dr. Carl R. Adkins of Fayetteville, President of the State Medical Association, was guest speaker for the meeting of the McDowell County Medical Society on October 12 at Stevens Clinic Hospital in Welch.

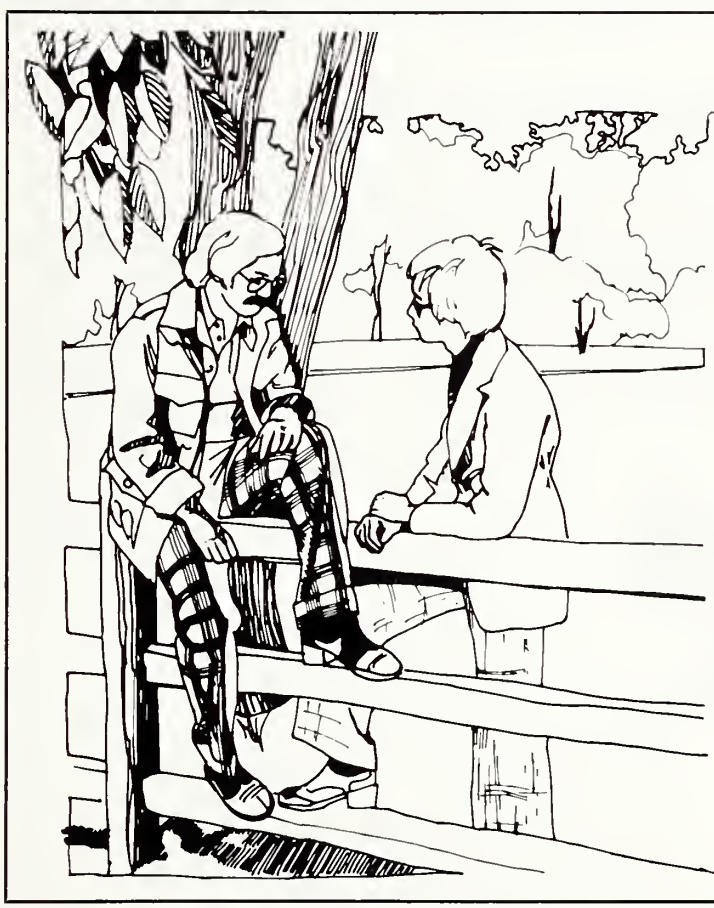
Doctor Adkins discussed the present status of physicians and the "political realities" of Medicine in the state of West Virginia. A lively question-and-answer period followed.—John S. Cook, M. D., Secretary.

* * *

HANCOCK

The Hancock County Medical Society met on September 20.

The Society voted to work with the State Health Department in investigating the reason for the high cancer mortality rate in this area.—Renee L. Lemal, Executive Secretary.



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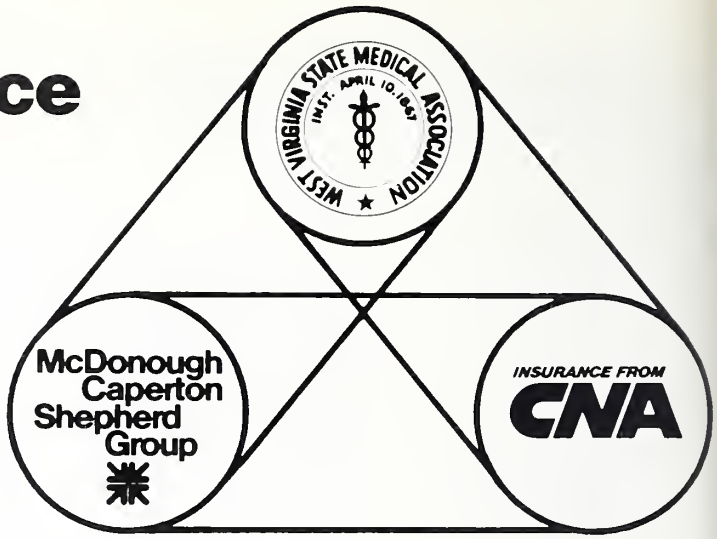

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Book Review

HANDBOOK OF POISONING, 11TH EDITION — Robert H. Dreisback, M. D., Ph. D. 632 pages. Price $11. Lange Medical Publications, Los Altos, California 94022. 1983.

Handbook of Poisoning is a useful, up-to-date reference source book on poisons and medical management of poisonings. The book has an excellent index comprising 71 pages with substantial cross-referencing which includes both generic and drug brand names. Besides the chapters on specific poisons, the first five chapters are devoted to poison prevention, emergency management of poisonings, diagnosis and evaluation of poisoning, basic general medical management of the patient, and medical/legal aspects of poisoning. These chapters are very readable.

The subsequent chapters are on specific poisonings. In these chapters the information is set forth concisely in an outline form which includes chemical information, clinical information (acute versus chronic poisoning), laboratory findings, treatment and prognosis. Following each section there is a good selection of recent review and clinical management articles. The reference listings have been updated since the last edition of the book published in 1980.

Changes in management for particular poisonings are seen when one compares the information given in this recent book with that in the last edition. For example, phosphate lavage is no longer recommended for iron poisoning, and physostigmine is not recommended for the management of cardiac arrhythmias resulting from tricyclic antidepressant overdose. Despite the updating of this book, the physician involved in the care of the poison victim would, in addition, probably consult the poison index found in emergency rooms for the most recent information.

Handbook of Poisoning is a useful book for the practicing pediatrician, pediatric house officer and physician dealing with poisonings. It should be included in any emergency medical reference library. — Dorothy J. Ganick, M. D.

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